MEETING OF THE COUNTIES MANUKAU DISTRICT HEALTH BOARD
Wednesday, 9 December 2020

Venue: Room 107, Ko Awatea, Middlemore Hospital
Time: 8.30 am

CMDHB BOARD MEMBERS	CMDHB MANAGEMENT
Mark Gosche – Chairman	Margie Apa – Chief Executive Officer
Tipa Mahuta – Deputy Chair	Margaret White – Chief Financial Officer
Apulu Reece Autagavaia	Dr Peter Watson – Chief Medical Officer
Catherine Abel-Pattinson	Dr Jenny Parr – Chief Nurse & Director of Patient & Whaanau Experience
Colleen Brown	Dinah Nicholas – Board Secretary
Dianne Glenn	
Garry Boles	
Katrina Bungard	OBSERVERS
Paul Young	Brittany Stanley-Wishart
Lana Perese	Tori Ngataki
Pierre Tohe	

PART 1 – Items to be considered in public meeting

AGENDA

		BOARD ONLY SESSION (8.30 – 9.00am)	Page No.
	1.	**GOVERNANCE**	
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	2.	**BOARD MINUTES**	
9.10am	2.1	Confirmation of Minutes of the Meeting of the Board – 28 October 2020 (Mark Gosche)	7-14
9.13am	2.2	Action Item Register (Mark Gosche)	15
9.15am	2.3	Report on the *Draft* Hospital Advisory Committee Minutes – 4 November 2020 (Catherine Abel-Pattinson)	16-24
9.20am	2.4	Report on the *Draft* Community & Public Health Advisory Committee Minutes – 4 November 2020 (Colleen Brown)	25-31
	3.	**EXECUTIVE REPORTS**	
9.25am	3.1	Chief Executive's Report (Margie Apa) 3.1.1 Patient Story (Jenny Parr)	32-70
9.35am	3.2	Health & Safety Performance Report (Elizabeth Jeffs)	71-101
9.45am	3.3	Corporate Affairs & Communications Report (Donna Baker)	102-116
9.55am	3.4	Finance & Corporate Business Report (Margaret White)	117-127
10.00am	3.5	Smokefree Policy & Designated Vaping Area (Gary Jackson/Basil Fernandes)	128-151
	4.	**FOR INFORMATION ONLY**	
	4.1	Alcohol Harm Minimisation Programme Update	152-166
	4.2	Franklin Locality Group Proposal	167-178
	5.	**RESOLUTION TO EXCLUDE THE PUBLIC**	
		Morning Tea Break (10.15 – 10.25am)	179-183

Board Member Attendance Schedule 2020

Name	Jan	19 Feb	Mar	1 Apr	20 May	24 Jun	July	5 Aug	23 Sept	28 Oct	Nov	9 Dec
Mark Gosche (Chair)**	No Meeting	✓	No Meeting	✓	✓	✓	No Meeting	✓	✓	✓	No Meeting	
Colleen Brown*		✓		✓	✓	✓		✓	✓	✓		
Dianne Glenn*		✓		✓	✓	✓		✓	✓	✓		
Reece Autagavaia*		✓		✓	X	✓		x	X	X		
Catherine Abel-Pattinson*		✓		✓	✓	✓		✓	✓	✓		
Katrina Bungard*		✓		✓	✓	✓		x	X	✓		
Garry Boles*		✓		X	✓	✓		✓	✓	✓		
Paul Young*		✓		✓	X	✓		✓	X	✓		
Tipa Mahuta (Deputy Chair)***		✓		✓	✓	✓		✓	✓	✓		
Lana Perese***		✓		✓	✓	✓		✓	✓	✓		
Pierre Tohe***		X		✓	✓	X		✓	✓	✓		
Brittany Stanley-Wishart******	*n/a*							X	✓	✓		
Tori Ngataki******	*n/a*							X	✓	X		

re-elected 14.10.19, effective 9.12.2019 – 5.12.2022; ** re-appointed 6.12.19, effective 9.12.2019 – 5.12.2022; ***appointed 6.12.19, effective 9.12.2019 – 5.12.2022; ** seconded effective 5.8.2020.*

BOARD MEMBERS' - DISCLOSURE OF INTERESTS
9 December 2020

New items in red italics

Member	Disclosure of Interest
Mark Gosche, Chair	• Trustee, Mt Wellington Licensing Trust • Director, Mt Wellington Trust Hotels Ltd. • Director, Keri Corporation Ltd • Trustee, Mt Wellington Charitable Trust • Chair, Kainga Ora Homes & Communities • Director, Housing NZ Build Ltd (subsidiary of KO Homes & Comms) • Director, Housing NZ Ltd (subsidiary of KO Homes & Comms) • Member, Expert Advisory Group to the Retirement Commissioner working on retirement income.

Catherine Abel-Pattinson	• Director, healthAlliance NZ Ltd.
	• Board Member, International Accreditation NZ (IANA)
	• Member, NZNO
	• Member, Directors Institute
	• Husband (John Abel-Pattinson):
	  ○ Director, Blackstone Group Ltd
	  ○ Director and Shareholder, Blackstone Partners Ltd
	  ○ Director Blackstone Treasury Ltd
	  ○ Director Bspoke Group Ltd
	  ○ Director, Barclay Management (2013) Ltd
	  ○ Director, AZNAC (JAP) Ltd
	  ○ Director Chatham Management Ltd
	  ○ Director, MAFV Ltd
	  ○ Director Wolfe No. 1 Ltd
	  ○ Director, 540 Great South Motels Ltd
	  ○ Director Silverstone Property Group Ltd
	  ○ Director, various single purpose property owning companies
	  ○ Director and Shareholder, various Trustee Companies related to shareholding in the above

Colleen Brown	• Chair, Disability Connect (Auckland Metropolitan Area) • Member, Advisory Committee for Disability Programme Manukau Institute of Technology • Member, NZ Down Syndrome Association • Husband, Determination Referee for Department of Building and Housing • District Representative, Neighbourhood Support NZ Board • Chair, Rawiri Residents Association • Director and Shareholder, Travers Brown Trustee Limited • Board Member, NZ Neighbourhood Support
Garry Boles	• NZ Police Constable
Katrina Bungard	• *Deputy* Chairperson MECOSS – Manukau East Council of Social Services. • Elected Member, Howick Local Board • Deputy Chair, Amputee Society Auckland/Northland • Member of Parafed Disability Sports • Member of NZ National Party

Dianne Glenn	• Member, NZ Institute of Directors • Life Member, Business and Professional Women Franklin • Member, UN Women Aotearoa/NZ • Past President, Friends of Auckland Botanic Gardens and Chair of the Friends Trust • Life Member, Ambury Park Centre for Riding Therapy Inc. • Member, National Council of Women of New Zealand • Justice of the Peace • Member, Pacific Women's Watch (NZ) • Member, Auckland Disabled Women's Group • Life Member of Business and Professional Women NZ • Interviewer, The Donald Beasley Research Institute for the monitoring of the United Nations Convention on the Rights of Persons with Disabilities. • Member, Lottery Individuals with Disabilities Committee
Lana Perese	• Director & Shareholder, Malatest International & Consulting • Director, Emerge Aotearoa Limited Trust • Trustee, Emerge Aotearoa Housing Trust • Director, Vaka Tautua • Director, Malologa Trust • Director & Shareholder, Perese Wood Investments Limited
Paul Young	• Director, Paul Young International Ltd • Councillor, Auckland Council
Pierre Tohe	• Senior Executive, Tainui Group Holdings • Trustee, Taniwha Marae
Reece Autagavaia	• Member, Pacific Lawyers' Association • Member, Labour Party • Trustee, Epiphany Pacific Trust • Trustee, The Good The Bad Trust • Member, Otara-Papatoetoe Local Board • Member, Pacific Advisory Group for Mapu Maia – Problem Gambling Foundation • Board of Trustees Member, Holy Cross School • Member of the Cadastral Surveyors Board • Assessor of the Creative Communities Scheme South & East Auckland
Tipa Mahuta	• Deputy Chair, Te Whakakitenga o Waikato • Councillor, Waikato Regional Council
Ken Whelan, Crown Monitor	• Board Member, Royal District Nursing Service NZ • Contracts with Francis Health & GE Healthcare (mainly Australia & Asia) • Crown Monitor, Waikato District Health Board
Brittany Stanley-Wishart, Board Observer	• Deputy Chair, Pasifika Students in Health in NZ (charity that receives funding from CM Health for its biennial conference)
Tori Ngataki, Board Observer	• Board member , Ngāti Tamaoho Trust 2016 to 2020 (restanding) • Board member , Second natures trust 2016 to 2021 • Marae Rep, Te Whakakitenga o Waikato Inc 2017 to 2021 (*restanding)* • Director, Keep it Māori Ltd (social enterprise) 2019

BOARD MEMBERS' REGISTER OF DISCLOSURE OF SPECIFIC INTERESTS

Specific disclosures (to be regarded as having a specific interest in the following transactions) as at 9 December 2020

Director having interest	Interest in	Due To	Disclosure date	Board Action
Mr Tohe	Potential Disposal of CM Health Owned Community Properties	Senior Executive, Tainui Group Holdings	28/10/2020	Mr Tohe's specific interest was noted and he was able to remain in the room and participate in any discussion but was excluded from voting.
Mr Gosche		Chair of Kainga Ora Homes & Communities	28/10/2020	Mr Gosche's specific interest was noted and he was able to remain in the room and participate in any discussion but was excluded from voting.
Ms Mahuta		Deputy Chair of Te Whakakitenga o Waikato Incorporated (governing body of Waikato-Tainui) due to the properties being subject to the Waikato Raupatu Settlement Claims Act 1995 whereby the iwi are required to be offered the first Right of Refusal	28/10/2020	Ms Mahuta's specific interest was noted and she was able to remain in the room and participate in any discussion but was excluded from voting.
Mr Tohe	Major Capital Works Committee – Appointment of Independent Advisors – Appointment of Mr Robert Batters		28/10/2020	Mr Tohe's specific interest was noted and he was able to remain in the room and participate in any discussion but was excluded from voting.
Ms Abel-Pattinson	Post Implementation Reviews – Histopathology Lab Relocation	Board member, International Accreditation NZ	23/9/2020	Ms Abel-Pattinson's specific interest was noted and she was able to remain in the room and participate in any discussion but was excluded from voting.

Director having interest	Interest in	Due To	Disclosure date	Board Action
Ms Abel-Pattinson	Sale of healthAlliance NZ Ltd Class C Shares	Board member, healthAlliance NZ Ltd	24/6/2020	Ms Abel-Pattinson's specific interest was noted and she was able to remain in the room and participate in any discussion but was excluded from voting.
Dr Perese	CEO Report Public Excluded – 12 month renewal of the MH&A contract for Emerge Aotearoa.	Board Member, Emerge Aotearoa Ltd	5/8/2020	Dr Perese's specific interest was noted and she was able to remain in the room and participate in any discussion but was excluded from voting.

Minutes of the Meeting of the Counties Manukau District Health Board

Wednesday 28 October 2020

Held at Counties Manukau DHB, Room 107, Ko Awatea, Middlemore Hospital, Hospital Road, Otahuhu

PART I – Items considered in public meeting

BOARD MEMBERS PRESENT

Mark Gosche (Board Chair)
Catherine Abel-Patterson
Colleen Brown
Dianne Glenn
Garry Boles
Katrina Bungard
Dr Lana Perese
Paul Young
Pierre Tohe
Tipa Mahuta
Brittany Stanley-Wishart (Board Observer)

ALSO PRESENT

Margie Apa (Chief Executive)
Margaret White (Chief Financial Officer)
Peter Watson (Chief Medical Officer)
Jenny Parr (Chief Nurse)
Dinah Nicholas (Board Secretary)

APOLOGIES

Apologies were received and accepted from Apulu Reece Autagavaia, Tori Ngataki (Board Observer) and Ken Whelan (Crown Monitor).

PUBLIC AND MEDIA REPRESENTATIVES PRESENT

Dr Steven Stelts was present for the public section of this meeting.

WELCOME

Mr Tohe opened the meeting with a karakia.

DISCLOSURE OF INTERESTS/SPECIFIC INTERESTS

There were no changes to the Disclosures of Interests.

Mr Tohe, Ms Mahuta and Mr Gosche declared specific interests in relation to Items 3.4 and 3.6 in the Public Excluded part of this meeting. These were noted in the Specific Interests Register.

AGENDA ORDER AND TIMING

Items were taken in the same order as listed on the Agenda.

2. BOARD MINUTES

2.1 Minutes of the Meeting of the Board 23 September 2020

The minutes were taken as read.

Mr Gosche confirmed that Ms Glenn, Ms Brown, Ms Bungard and Dr Perese had all expressed interest in being on the new local DiSAC Committee. Mr Nand to schedule a meeting to draft a Terms of Reference for the Committee for ratification at the 9 December Board meeting.

Resolution (Moved: Ms Glenn/Seconded: Mr Tohe)

That the Minutes of the Board Meeting held on the 23 September 2020 be approved.

Carried

2.1 Action Item Register

Noted.

2.3 Draft Minutes of the Meeting of the Hospital Advisory Committee 9 September 2020

The minutes were taken as read.

2.4 Draft Minutes of the Meeting of the Community & Public Health Advisory Committee 9 September 2020

The minutes were taken as read.

3 EXECUTIVE REPORTS

3.1 Chief Executive's Report (Margie Apa)

The paper was taken as read.

Patient Story – Ms Parr read a Patient Story which made reference to the Middlemore Hospital patient meals. The Hospital Advisory Committee are to undertake a yearly review and tasting of the patient meals.

[Ms Mahuta arrived at 10.20am]

Research Week – Research Week ran from 12-16 October and showcased health research from within CM Health and beyond with many experts in their fields visiting and speaking throughout the week. The DHB is fortunate to be supported by a number of sponsors – Middlemore Clinical Trials, AUT, Auckland Medical Research Foundation and Fisher & Paykel Healthcare.

The Board asked that letters of congratulations be sent to all the winners.

Signage – Te Reo Maaori is becoming much more visible at the DHB. The signs for the Ko Awatea pay station and the library at Middlemore Hospital are just two examples of an organisation-wide commitment to bilingual signage. The first roll out of signage began during Wiki o Te Reo Maaori (Maaori Language Week) and also included the Emergency Department. The DHB is using the Tainui spelling (double 'aa').

Manukau Health Park Windbreak – a windbreak was installed at the Manukau Health Park entrance in October. The structure is made of glass and has used the beauty of flowers to represent the many people and cultures who visit and use the facility.

Performance – ED performance has improved from last year. In August, 93% of patients were discharged from ED within 6hrs. This is a big improvement from August 2019 where 78% were discharged within 6hrs.

Mr Tohe noted that MRI & CT scans for Maaori were considerably lower than for Pacific and European. Ms Apa undertook to look into what the reasons for this are and report back in the next CEO report on 9 December.

Youth 10 Survey – during September, the DHB hosted the presentation of the Youth 19 survey of health and wellbeing for young people in the Counties Manukau region. The survey was part of the Youth 2000 series which has surveyed over 36,000 young people in Aotearoa since 1999 with findings used to inform policy and practice. A link to the Youth19 survey is below:
https://www.youth19.ac.nz/

Resolution (Moved: Dr Perese/Seconded: Mr Young)

That the Board:

Receive the Chief Executive's Report for the period 24 September – 27 October 2020.

Carried

3.2 Health & Safety Performance Report (Elizabeth Jeffs & Kathy Nancarrow)
The report was taken as read.

Mask Fitting – in response to the increased demand experienced following the COVID19 community outbreak in August, the OH&S service increased the availability of respirator mask fit testing by utilising an external provider to prioritise areas for testing that were identified as being where the potential risk of exposure was highest. Work is underway to establish a long term testing programme across the DHB.

Ms Mahuta noted that no Maaori appear to be accessing EAP. Ms Jeffs advised that they are more likely to access Kaumatua support/pastoral care, and it will be important to try to capture and count that somehow going forward.

3.2.1 Workforce Ethnicity Reports to June 2020 (Elizabeth Jeffs)
The reports were taken as read.

Ms Jeffs to present the Workforce Strategy Plan to the Board in the New Year (date tbc) including how the DHB will accelerate the pipeline of students coming into the DHB, particularly for Maaori & Pacific and what the retention plan is.

Resolution (Moved: Ms Abel-Pattinson/Seconded: Ms Glenn)

That the Board:

Receive the Health & Safety Performance Report for the period of August 2020 and the Workforce Reports to June 2020.

Carried

3.3 Corporate Affairs & Communications Report (Donna Baker & Jared Heffernan)
The report was taken as read.

ED Documentary – the DHB has been approached by a documentary production company, Storymaker, for permission to work with the DHB to make an eight part documentary series based on the Emergency Department at Middlemore Hospital. This would require access to staff and consented patients. Storymaker has been given approval to seek funding from NZ on Air however, further issues will need to be addressed before any contract is signed by the DHB.

Tiaho Mai Official Opening – the official opening is waiting for the announcement of the new Minister of Health.

The Chair, on behalf of the Board, congratulated the Communications Team for all their work throughout COVID.

Resolution (Moved: Ms Glenn /Seconded: Mr Young)

That the Board:

Receive the Corporate Affairs & Communications Report for the period of September 2020.

Carried

3.4 Finance & Corporate Business Report (Margaret White)
The report was taken as read.

Financial Result - the underlying variance for August is $117k favourable against budget and $94k favourable YTD.

2020/21 Budget – the Board approved a $29.289m budget deficit for the year ended 30 June 2021. On 20 October, the DHB received confirmation from the Ministry that the 2020/21 Annual Plan (one year) has been approved by the Joint Ministers.

COVID – making good progress with the Ministry on funding flows.

Cash Position – this remains strong but the DHB has isssued a request for a Letter of Comfort from Joint Ministers.

Resolution (Moved: Mr Gosche/Seconded: Ms Glenn)

That the Board:

Receive the Finance Report.

Carried

5. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (Moved: Mr Gosche/Seconded: Ms Abel-Pattinson)

That in accordance with the provisions of Schedule 3, Clause 32 and Sections 6, 7 and 9 of the NZ Public Health and Disability Act 2000:

Ms Brittany Stanley-Wishart is allowed to remain for the Public Excluded section of this meeting.

The public now be excluded from the meeting for consideration of the following items, for the reasons and grounds set out below:

General Subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
Public Excluded Minutes of 23 September 2020 and 14 October 2020	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Confirmation of Minutes** As per the resolution from the public section of the minutes, as per the NZPH&D Act.
Public Excluded Minutes of Audit Risk & Finance Committee, Hospital Advisory Committee & Community & Public Health Advisory Committees, People & Culture Sub-Committee	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Confirmation of Minutes** As per the resolution from the public section of the minutes, as per the NZPH&D Act.
COVID19 Capital Purchases	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]

Bad Debt Write Offs	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Privacy** The disclosure of information would not be in the public interest because of the need to protect the privacy of natural persons. [Official Information Act 1982 S9(2)(a)]
MCIS Upgrade Business Case	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]
Potential Disposal of CM Health Owned Community Properties	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities and Negotiations** The disclosure of the information would not be in the public interest because of the greater need to enable the organisation to carry on, without prejudice or disadvantage, commercial activities and negotiations. [Official Information Act 1982 S9(2)(i) & (j)
Scott Passive Fire & En-suite Refurbishment Business Case	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]
Major Capital Works Appointment of Independent Advisors	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Position** The disclosure of the information would be likely to prejudice the commercial position of the person who supplied or who is the subject of the information. [Official Information Act 1982 S9(2)(ii)]

2019/20 Annual Report	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Confidentiality of advice by officials** The disclosure of the information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by Ministers of the Crown and officials. [Official Information Act 1982 S9(2)(f)(iv)
COVID 19 Governance/Decision Making	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]
Ratification of Circular Resolution – BSN Medical	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Negotiations** The disclosure of the information would not be in the public interest because of the greater need to enable the organisation to carry on, without prejudice or disadvantage, commercial negotiations. [Official Information Act 1982 S9(2)(i) & (j)
Ratification of Circular Resolution – Kidz First Neonatal Additional Capacity & Refurbishment Business Case	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]
Chief Executive's Report	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Public Interest** The disclosure of information is necessary to protect information that would be likely to otherwise damage the public interest. [Official Information Act 1982 S9(2)(ba)(ii)]

Draft Board Dashboard	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]
Strategy & Infrastructure Report	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities and Negotiations** The disclosure of the information would not be in the public interest because of the greater need to enable the organisation to carry on, without prejudice or disadvantage, commercial activities and negotiations. [Official Information Act 1982 S9(2)(i) & (j)
DDOS Northern Region Response	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]

Carried

The public meeting closed at 11.10am.

THE NEXT MEETING OF THE COUNTIES MANUKAU DISTRICT HEALTH BOARD WILL BE HELD ON WEDNESDAY 9 DECEMBER 2020.

SIGNED AS A CORRECT RECORD OF THE COUNTIES MANUKAU DISTRICT HEALTH BOARD, BOARD MEETING HELD ON 28 OCTOBER 2020.

BOARD CHAIR **DATE**

Counties Manukau District Health Board
Action Items Register (Public)

DATE	ITEM	ACTION	DUE DATE	RESPONSIBILITY	COMMENTS/UPDATES	COMPLETE ✓
23 September 2020	**Chief Executive's Report**	Come back to the Board with advice on what the resource implications and the upside/downsides would be to opening up the age restrictions for Bowel & Breast screening.	9 December	Margie Apa	*Refer Public Excluded agenda for this meeting*	✓
5 August 2020	**First Draft Northern Region Service Plan**	Alcohol Related Harm – present the current work programme to the Board for update.	9 December	Gary Jackson	*Refer Item 4.1 on today's agenda.*	✓
20 May 2020	**CEO Report**	Patient Story on how Fathers are Treated on the Maternity Ward - invite the Chief Midwfie to attend October Board meeting to provide an update on the changes made in the maternity service as a result of this patient story.	9 December	Christina Mallon	*Refer Item 3.1 on the Public Excluded agenda.*	✓

Minutes of Counties Manukau District Health Board
Hospital Advisory Committee

Held on 4 November 2020 at 1.00pm
Ko Awatea Room 101, Middlemore Hospital
100 Hospital Road, Otahuhu, Auckland

PART I – Items Considered in Public Meeting

BOARD MEMBERS PRESENT

Catherine Abel-Pattinson – HAC Chair
Vui Mark Gosche - CMDHB Chair
Colleen Brown – CMDHB Board Member
Dianne Glenn – CMDHB Board Member
Katrina Bungard – CMDHB Board Member (via Zoom)
Apulu Reece Autagavaia – CMDHB Board Member (via Zoom)
Robert Clark – Mana Whenua

ALSO PRESENT

Avinesh Anand – Deputy CFO Provider
Dr Jenny Parr – Chief Nurse and Director of Patient and Whaanau Experience
Jessica Ibrahim - Executive Advisor, CEO's Office
Margie Apa – Chief Executive Officer
Mary Burr – General Manager Women's Health
Dr Peter Watson – Chief Medical Officer
Sanjoy Nand – Chief of Allied Health, Scientific & Technical Professions
Teresa Opai – Secretariat
(Staff members who attended for a particular item are named at the start of their item)

PUBLIC PRESENT

Rowan Quinn - Radio New Zealand

1. COMMITTEE ONLY SESSION

The Committee only session commenced at 1.10 pm. The DHB Management team joined the meeting at 1.30pm. Mr Clark opened the meeting with a Karakia.

2. AGENDA ORDER AND TIMING

Agenda items were taken in the same order as listed on the agenda.

2.1 Apologies/Attendance Schedule

Dr Lana Perese, Ms Tipa Mahuta, Mr Paul Young, Mr Garry Boles, Mr Barry Bublitz, Ms Brittany Stanley-Wishart (Observer), Ms Tori Ngataki (observer).

2.2 Disclosed Interests

Ms Glenn advised that she was now a Life Member, Friends of Auckland Botanic Gardens.

2.3 Special Interests

There were no Special Interests to note requiring update.

3. CONFIRMATION OF MINUTES

3.1 Minutes of the Hospital Advisory Committee Meeting – 9 September 2020

Ms Glenn advised that item 5.1 in the Minutes and Action Register refers to 'cervical smears' when it should read 'vaginal smears'.

Resolution (Moved: Ms Glenn/Seconded: Ms Brown)

That the Minutes of the Hospital Advisory Committee held on 9 September 2020 be approved.

Carried

3.2 Action Items Register – Public

Noted.

4. PROVIDER ARM PERFORMANCE REPORT

4.1 Executive Summary (Mary Burr)

The report was taken as read. Ms Burr provided key points:

- All references are to the month of September.
- The hospital operated at Covid-19 level 2.5 until 21 September and then level 2 for the remainder of the month. Covid-19 activities focussed on recovery and planning for any resurgence.
- Priority 1 national targets for colonoscopy and gastroscopy were achieved.
- Faster Cancer Treatment target achieved at 100% for the month of September with Q1 results 91% for the 62-day measure and 93% for the 31-day measure.
- The migration of Tui ward to the new Whai Oranga ward in Tiaho Mai was achieved.
- Total Planned Care delivery for August was confirmed by the Ministry at 109.8%, with the indicative result for September at 100%.
- Eight extra Gynaecology beds in Ward 21 have been made available in September in addition to the 15 beds in the Gynaecology Care Unit.
- The Ministry of Health (Ministry) has recommended that a decision regarding the lowering of the age for Maaori and Pasifika participants in the National Bowel Screening Programme be deferred until the end of 2021 when the programme has been rolled out to all DHBs. A total of 122 cancers have been diagnosed since the programme commenced in the DHB in July 2018.
- Immunisation of 8-month olds over the past three months has declined by 1% for the total population, 5% for Maaori and 1% for Pasifika. The Outreach Immunisation team are fielding a greater number of calls than usual from Maaori and Pasifika families who had previously vaccinated but who were feeling anxious and uncertain about the effects of vaccines on their babies, or wanting to delay appointments, possibly due to Covid-19 concerns. Enabling the team to engage with families in their homes has proved invaluable.
- An additional 7.2 FTE laboratory staff have been recruited to specifically focus on Covid-19 testing with a surge plan developed to enable the ability to test up to 2200 tests per day. Staff wellbeing is being actively managed and staff from other departments have reached out to provide support to enable staff to take some time off.
- A review of the neonatal unit occupancy levels during the Covid-19 Level 3 and Level 4 lockdowns was conducted by Neonatologist Guy Bloomfield. Conclusions of the review are:
  - The decreased occupancy in Kidz First Neonatal Care (KFNC) during April and May with a shorter length of stay was due to fewer premature babies being born and admitted.
  - There was an increase in telephone and non-contact obstetric interactions.
  - International reports indicate a reduction in premature birth rates in Denmark and Ireland and an increase in stillbirth in Britain.

    - The KFNC numbers are probably insufficient to provide a robust answer but will continue to be monitored.
- Ophthalmology waiting times have returned to pre-Covid-19 levels. Significant additional work has taken place to achieve this, including Saturday and evening clinics.
- MRI production has increased as a result of weekend and evening sessions and the focus is now turning to P2 MRIs.
- The Shorter Stays in ED performance against target is being impacted as the DHB returns to BAU.

Ms Brown asked what the rationale was behind deferring the decision on reducing age eligibility for bowel screening for Maaori and Pasifka. Ms Burr advised that it was a Ministry mandate.

Ms Abel-Pattinson referenced a discussion at a previous HAC meeting regarding bowel screening for Maaori and Pasifika who were ineligible (age restricted) under the Ministry's programme where the Committee asked how much it would cost and how many extra screenings the DHB would have to undertake in order to make an improvement for its population. Ms Abel-Pattinson asked that this be added back into the action items for follow-up.

Action: ***Secretariat to review past minutes and action points for references to the DHB funding bowel screening tests for Maaori and Pasifika who were ineligible (age restricted) under the Ministry programme and add it to the action items.***

4.2 Hospital Services Project Portfolio Overview (Mary Burr)

The report was taken as read. Ms Burr provided key points:

- Seventy five total projects are being monitored. Of these 10 are currently in initiation, 17 in planning, 34 in execution, 10 in close out, 2 in operations and 2 on hold.
- Progress in quarter one has been challenging due to the redirection of effort toward the organisation's Covid-19 response.

4.3 Finance Results – CMDHB Provider Arm (Avinesh Anand)

The report was taken as read. Mr Anand provided key points:

- Underlying result of $2.1M favourable to budget was achieved for the month of August, $583k favourable YTD.
- $8.2M from the Ministry for planned care is yet to be received.
- August result: Orthopaedics YTD 24% over-delivered on volumes, Acutes are 87% of last year, ED is down by 16% but admission into inpatient wards has increased compared to same time last year by 5% and length of stay has also gone up.
- September result: break even for the month and $572k YTD, Orthopaedics are 19% and are expecting funding shortly, Acutes are 4.9% of last year.
- The majority of the E$C portfolio had been paused as project team members were redeployed to support tactical Covid-19 projects.

Dr Watson advised that since 9 April 2020, 45,000 arrivals into New Zealand have been processed through the quarantine facilities in Auckland.

Resolution (Moved: Ms Glenn/Seconded: Ms Brown)

That the Hospital Advisory Committee:

Note and receive the Provider Arm Performance reports.

Carried

5. CORPORATE REPORTS

5.1 HPV Self-testing/WDHB Study Opportunity (Dr Jon Mathy)

Dr Mathy provided a verbal update about the human papilloma virus (HPV) self-testing for cervical screening research. Key points:

- Dr Mathy believes self-testing will improve outcomes in the DHB catchment and the DHBs clinical leads also believe it is a good idea.
- Self-testing is not currently funded in New Zealand so the only opportunity is to introduce this on a research level.
- A research project is currently being investigated, led by Dr Karen Bartholomew (WDHB) and if funding is successful, CMDHB could join the study. However, CMDHB would need to be prepared for the follow-up colposcopies that will eventuate from the study, approximately 100-150 additional tests in a one-year period. As the DHB is at capacity for these, the only option would be additional Saturday clinics which do not have funding.
- Dr Mathy advised that the Ministry do not want to divert progress on existing screening by introducing self-testing.

Ms Abel-Pattinson asked if costings were available on what it would take to fund a Saturday clinic. Ms Burr advised this was currently being worked through. Dr Mathy advised he could prepare costings.

Dr Watson suggested a Population Health perspective of cervical screening in the context of a wider programme around cervical cancer prevention, detection and treatment rather than just focussing on one aspect and that Dr Gary Jackson would be well placed to speak about that more broadly.

Dr Mathy suggested we invite Dr Jackson to provide some population health analysis and how the prevalence is shifting since the introduction of the vaccine.

Dr Parr noted that Dr Mathy is not responsible for doing this research and suggested that we ask Dr Jackson to look at opportunities and how the DHB might be able to do this and that Dr Jackson liaise with Dr Bartholomew who is in the WDHB Population Health team.

Ms Abel-Pattinson stated her preference would be to prepare a quick paper looking at how much this would cost. The paper should note the opportunity to reduce the incidence of cancer earlier, treat it earlier, and improve health outcomes and long term savings.

Dr Parr queried why this was a HAC issue and not CPHAC. Ms Abel-Pattinson believes it falls under the remit of improving health outcomes for cancer and screening is the DHBs first line of defence. Mr Gosche suggested the information be gathered and tested against the Population Health approach.

Action: ***Dr Mathy to prepare costings based on the provision of 100-150 additional colposcopies over one year, how many Saturday clinics would be required, the number of staff to run the clinics and combine this with some population health analysis to provide a broader picture. Report back at the January meeting.***

5.2 Smokefree Policy and Designated Vaping Area (Basil Fernandes, Dr Gary Jackson, Dr Sarah Sharp)

The report was taken as read. Dr Jackson advised that the report had been discussed at CPHAC and was provided to HAC in order to respond to any questions the Committee may have.

Mr Gosche noted that a previous version of this proposal had been discussed by a different Board last year and advised that a full presentation of the current proposal would need to go to the new Board to seek their direction before it is taken any further.

Action: ***Smokefree Policy and Designated Vaping area papers to be referred back to the Board for a full presentation of the current proposal and to seek the Board's direction before any further action is taken.***

Resolution (Moved: Ms Glenn/Seconded: Ms Brown)

That the Hospital Advisory Committee:

Note and receive the report.

Refer the report back to the Board for a full presentation before any further action is taken.

Carried

5.3 MedChart Sentinel Events (Sanjoy Nand, Marie Lewis, Rebecca Lawn)

Mr Nand provided a presentation. Key points:

- MedChart replaces the national medical chart and rollout commenced in April 2019.
- Eighty-six percent of all inpatient beds are now utilising MedChart with future rollouts to Surgical pre-admit clinics, Paediatrics (2021), Tamaki Oranga and Interventional Radiology. MedChart is not used in Critical Care at this point due to the prescribing and administering of complex and dynamic medication infusions.
- Prescribing errors per patient have reduced considerably following the introduction of MedChart.
- Integration of electronic systems has improved medication safety. Patient profiles reviewed have increased from 30,000 to 80,000 per month since the introduction of MedChart and upgraded dispensing software. Almost every medication is reviewed on MedChart by pharmacists across the hospital which would not have been achievable with the previous paper system.
- There is room for quality improvement in the area of clinical decision support as currently there are too many broad alerts.
- Challenges include alert fatigue, culture shift, adapting software to on-ward worfklows, and complex infusions (hybrid system).
- Future integration is planned with eVitals, Labs, MCIS and eMedRec.

5.4 Virtual Site Tour: Tiaho Mai Stage 2 (Dr Ian Soosay, Charles Tutagalevao)

A video was played to the meeting.

5.5 Operational Deep Dive: Mental Health and Addictions (Dr Ian Soosay, Charles Tutagalevao)

Dr Soosay and Mr Tutagalevao provided a presentation. Key points:

- The division employs approximately 800 FTE with a staff ethnicity similar to the DHBs community.
- The workforce is youthful and length of service peaks at 1-2 years although expecting to see this increase due to impact of Covid-19.
- Services are provided from acute hospital care and community outpatient care through to home visiting and respite care, catering for people of all ages.
- Service users and whaanau are at the centre of the service and are able to access a suite of services with less fragmentation that are culturally responsive, clinically safe and closer to home.
- Access rates for Maaori and Pasifika continue to meet Ministry targets and are high users of the service.
- Wellness support rates are pleasing, within GP practice users able to access funded interventions in the community.
- There is an increasing number of service users accessing secondary services.
- The DHBs peer support workforce (NGO and DHB) is the largest in Australasia.
- Covid-19 resulted in a significant increase in telehealth interventions with 67% of clinicians able to transition their approach to service user care during alert Level 3 and Level 4.
- Workforce pressure is a national issue but the DHB has seen some improvement in psychiatry and nursing vacancies in recent times and is leading the investment in Nurse Practitioners with three in place and a further two coming on-line in 2021.

Mr Gosche noted the lack of younger peer support workers and asked how the DHB could develop its workforce strategy as a career choice and a pathway into other health careers. Mr Gosche is interested to see the underlying vacancy problem. Dr Soosay advised that some areas are improving quite quickly, such as psychiatry, and more locals staying. The Junior Registrars training scheme is over-subscribed and Nursing is still a challenge.

Ms Glenn asked how many workers had returned from overseas since Covid-19. Dr Soosay advised the number was low, but more importantly people were not moving away. However, if Australia reopens its borders, it might become challenging again.

5.6 Certification Quarterly Update (Dr Jenny Parr)

The report was taken as read. Dr Parr provided key points:

- Twelve Corrective Actions (CARs) were received in the May 2019 certification audit. All 12 CARs will be followed up by the DAA Group during the surveillance audit to be conducted 8-10 December 2020.
- Steady progress is being made with the majority of the CARS and planning is well underway for the December surveillance audit.
- Internal patient tracer auditing was undertaken on 23 September 2020 within the divisions of Medicine, SAPS, Kidz First and ARHOP. The DAA Group will undertake patient tracer audits in the divisions of Mental Health and Women's Health during the surveillance audit in December 2020.
- Staffing shortages and skill mix will not be closed, but work is happening in this area.
- An unintended consequence of the pandemic is the number of rewritten policies in short periods of time which has resulted in the DHB having an issue with the area of controlled documents. Controlled document management as a whole is tracking in the right direction with an improved BAU system.

Mr Nand advised that T.Doc (theatre instrument tracing), is a software programme used to ensure the DHB knows where instruments are during different processes of the instrument journey. A business case for T.Doc was presented to ELT yesterday. Ms Abel-Pattinson asked if swabs in included in the system. Mr Nand was not sure if consumables were included, as the focus is on pre-theatre not peri-operative and on reusable medical devices.

Resolution (Moved: Mr Clark/Seconded: Ms Brown)

That the Hospital Advisory Committee:

Note and receive the report.

Carried

Mr Gosche left the meeting at 3.15pm. A Quorum remained.

5.7 Strategic Deep Dive: Fundamentals of Care March 2020 Peer Review Results (Dr Jenny Parr, Mrs Penny Johnstone)

The report was taken as read. Dr Parr provided key points:

- Methodology change to previous reviews in that notice of the review was given to the ward on the day rather than weeks in advance as done previously.
- The organisational score has reduced slightly compared with the previous review but was not significant.
- Due to wards only receiving their March results recently, their ability to improve on them during the October review was significantly constrained, so potentially little change will be seen. The large turnover of CNMs over the past 10 months will also impact the result, particularly Part C.
- There are some significant differences in ethnicities and their experience, with Maaori having a less satisfactory experience than other ethnic groups. In the March review this was reflected in three of the nine domains and in the previous review was reflected in five of the nine domains, so there has been a slight improvement.
- A paper on the Maaori Centred Models of Care Consultation is going to ELT next week for consideration as a standard for the approach going forward.
- Two Health Research Council-funded grants have been achieved, one of which will advance a Maaori nurse to start her career around research and to validate with the Maaori community to ensure it is aligned.
- When comparing results from the first review in December 2017 to the March 2020 review, the ward variation is reducing and the means are increasing across all nine domains.
- Work continues nationally with Waitemata, Mid Central and Southern DHBs on the Fundamentals of Care standards, which will be reflected in the Maaori standards of care.
- Of note, the information paper item 6.1 is the Inpatient Context of Care which is essentially one of the components of the FoC framework. This demonstrates that FoC is not a nursing issue, but rather a healthcare requirement for the DHB to provide.

Mr Nand noted that disability questions have been included in the October review and once reported to HAC, could be exported and reported to DiSAC also.

Resolution (Moved: Mr Clark/Seconded: Ms Glenn)

That the Hospital Advisory Committee:

Note and receive the report.

Carried

Ms Bungard left the meeting at 3.30pm. A Quorum was no longer present.

All resolutions made after this time are to be circulated to those Committee members who were present at the start of the Public meeting, for their approval.

5.8 Case Study: ED Discharge and Care Plan Maaori Health (Sharon McCook, Delanie Nepia)
Ms McCook and Ms Nepia provided a presentation in response to a request for a case study at the previous HAC meeting. Key points:

- The Te Kaahui Ora mobile unit was implemented on 1 September 2020 as a short-term initiative. Conclusive data should be available at the end of November indicating how the DHB can best utilise existing services to close the gap.
- The mobile unit focuses on supporting Maaori discharged/self-discharged from ED who have unmet health or social needs.
- Ten percent of presentations leave ED before being seen or leave against medical advice.
- All referrals are contacted by phone initially, then via cold call if deemed safe to do so.
- Seventy-seven percent of patients have been engaged with since the unit began operating.
- Three case studies were presented to the meeting.

Ms Abel-Pattinson acknowledged the work being done and requested another presentation in six months.

Action: ***Secretariat to schedule a further ED Discharge and Care Plan Maaori Health presentation in six months' time.***

6. INFORMATION ONLY

6.1 Inpatient Experience: Context of Care

6.2 CCA Impact of Covid on Cancer Services – Report 5 October 2020

Noted.

7. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (Moved: Ms Glenn/Seconded: Mr Clark)

That the Hospital Advisory Committee in accordance with the provisions of Schedule 3, Clause 32 and Sections 6, 7 and 9 of the NZ Public Health and Disability Act 2000:

The public now be excluded from the meeting for consideration of the following items, for the reasons and grounds set out below:

General subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
Public Excluded Minutes of 9 September 2020	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Confirmation of Minutes** As per the resolution from the public section of the minutes, as per the NZPH&D Act.
Funder Report	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities and Negotiations** The disclosure of information would not be in the public interest because of the greater need to enable the organisation to carry out, without prejudice or disadvantage, commercial activities and negotiations.

Carried

The Public Meeting closed at 3.44 pm.

The next meeting of the Hospital Advisory Committee will be held on Wednesday, 16 December 2020.

Signed as a true and correct record of Counties Manukau District Health Board's Hospital Advisory Committee meeting held on 4 November 2020.

Catherine Abel-Pattinson
Chair

Date

Minutes of Counties Manukau District Health Board
Community and Public Health Advisory Committee

Held on Wednesday, 4 November, 2020 at 9.00am – 11.30pm
Room 101, Ko Awatea, 100 Hospital Road, Middlemore Hospital, Otahuhu, Auckland

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PART I – Items considered in Public Meeting

BOARD MEMBERS PRESENT

Colleen Brown (Co-Chair)
Dianne Glenn
Katrina Bungard
Vui Mark Gosche (Board Chair)
Apulu Reece Autagavaia
Robert Clark (Mana Whenua)
Tipa Mahuta

ALSO PRESENT

Fepulea'i Margie Apa (CEO, CM Health)
Dr Gary Jackson (Director, Population Health)
Aroha Haggie (Director, Funding & Health Equity)
Dr Sue Tutty (GP Liaison, standing in for the seconded Dr Campbell Brebner)
Jessica Ibrahim (acting Executive Advisor to the CE)
Vicky Tafau (Secretariat)
(Staff members who attended for a particular item are named at the start of the minute for that item)

PUBLIC AND MEDIA REPRESENTATIVES PRESENT

No media representatives were in attendance.

WELCOME

The meeting commenced at 9.10am with a karakia from Robert Clark. The meeting was without a quorum until Tipa Mahuta joined the meeting shortly thereafter at 9.18am.

1. AGENDA ORDER AND TIMING

Items were taken as per the agenda.

2. GOVERNANCE

2.1 Apologies

Apologies were received from Pierre Tohe, Barry Bublitz, Lana Perese and Paul Young and both of the Board Observers, Brittany Stanley-Wishart and Tori Ngataki.

2.2 Register of Interests

Amendments to the Disclosure of Interests – amendments were noted and will be updated by Ms Tafau.
Amendments to the Disclosure of Specific Interests – no disclosures to note.

2.3 Confirmation of the Minutes of the joint Hospital Advisory Committee/Community and Public Health Advisory Committee/Disability Advisory Committee meeting held on 9 September 2020.

Resolution (Moved: Dianne Glenn/Seconded: Colleen Brown)

That the minutes of the Community and Public Health Advisory Committee meeting held on 9 September 2020 be approved.

Carried

2.4 Action Items Register/Response to Action Items

Items progressing as per schedule.

2.5 CPHAC Work Plan 2021

CPHAC advised that we should be mindful of the Minister's expectations when planning. Refer to the planning notes from early 2020 and the members list of priorities. CPHAC would like to see greater involvement from community. There was a request to include the maternity action plan.

3. STANDING ITEMS

3.1 **ARPHS 6-Monthly Update to CPHAC & ARPHS Covid-19 Response Review** (Dr William Rainger, Director ARPHS & Jane McEntee, CM ARPHS)

The paper was taken as read.

Ms Mahuta was interested in regard to healthy food in schools and where we intersect with other agencies in regard to keeping in line with the policy. Ms McEntee advised that there are two areas; Healthy Act of Learning and also Healthy Auckland Together (25 partners, will take some time to get traction).

Ms Mahuta Tipa to send link to Healthy Food boxes to Ms McEntee so she can advise the team.

Vui Mark Gosche (Vui) asked about the Covid Testing Strategy. ARPHS advised they are not involved with this.

Action
Covid Testing Strategy: CM Health Board wish to be kept up to date with where this strategy is at, due to workforce at places like hotels and Americold type workplaces, are likely to be South Auckland residents.

Public Health messaging was raised as an issue throughout the community. Need to ensure consistent messaging across the board.

Vui advised that as CM Health refresh their strategy over the coming months, we have to put a big emphasis on Public Health and prevention.

Apulu Reece Autagavaia (Apulu) raised the idea of incentivising workplaces to increase sick leave. ARPHS has suggested that there needs to be a Central Government Agency discussion, involving MBIE and Worksafe regarding that issue.

Apulu also raised alcohol signage and the fact that the current regulatory bi-laws will not be followed as the committee wants something stronger. Dr Rainger advised that ARPHS conducted the research that found widespread non-compliance. ARPHS staff are engaging with the council staff with their strong recommendations, which didn't seem to be taken through to the regulatory committee. The committee itself took a stronger and more health aligned view. Dr Rainger is not sure that is going to result in stronger enforcement by council staff. The whole regulatory scheme is not optimal at the moment. It has taken 10 years to get to the current point.

Dr Jackson had a query regarding Public Health core funding going forward. Dr Rainger advised that there have been no signals from the Government to date.

3.2 **20/21 Metro Auckland SLM Improvement Plan Q1 – Quarterly Report** (Matt Hannant, GM Primary Funding & Development)

The paper was taken as read.

It is early in terms of this year's plan. Everything is on track – tracking against the items we said we would, however COVID has had a profound impact as you can see from the data.

Ms Glenn raised the issue of the difficulty she found in signing up to a GP portal and the fact that she couldn't sign up herself and her husband using a single email address. Dr McIntosh advised this was to maintain patient confidentiality. Mr Hannant advised that we want to encourage whanau to have more input into their own healthcare and one of the issues is that GP portals are driven by the market and multiple different portals have been created. GPs have varying levels of uptake and there is varying levels of what is available. Primary Care is advocating for simpler access for whanau and are looking at standardisation. Uptake for Maaori was raised and Mr Hannant advised that current data isn't readily available but Mr Hannant felt that we are a long way off where we want to be for all whanau.

Ms Mahuta raised her concern around there not being a mental health indicator. Mr Hannant advised that plan was very big this year, however CM Health have made a deliberate effort to be focused. The DHB does a significant amount of work in the Mental Health space, which isn't reflected in the plan. There has been money spent on helping hire Health Improvement Practitioners and Health Coaches to support mental health and wellbeing. Mr Hannant agreed it was not reflected in the plan but will take this away and will include when they think about planning for next year.

Ms Brown raised her concern that Cancer was also missing, however she was pleased to see that Youth was included.

Ms Haggie felt it was worthwhile noting that we are able to bring back to the Committee some Faster Cancer Treatment reporting data which has got some very specific KPIs in it. The second thing is that there is a National Mental Health (?) Programme which we can get the team to do a presentation on so you can see the components in terms of the outcomes that the system is looking at in terms of Mental Health and it does have some Primary Care components in it.

Mr Hannant noted that this plan certainly doesn't reflect all of the improvement work being done in CM Health. Vui advised that this plan is what has been requested by the MoH. Ms Haggie added that there is a very rich work programme that goes on beneath the plan and it is hard to represent and it is also about the collaboration between all of the PHOs and particularly down into their practices and how they work on these things.

Vui asked if there was anything this committee should be concerned about due to the impact of Covid? Mr Hannant advised they were concerned around immunisations rates and have received a letter from the Director General asking CM Health to focus on this as a priority. Rates are definitely impacted by Covid. ELT's work programme has a deep dive on Immunisations to pick apart what is happening there. Ms Haggie will come back to the committee as soon as they can with the plan of where they need to focus. Dr McIntosh advised that whilst Primary Care functioning as normal it is whether people wish to return to Primary Care. The underlying factors will take some careful consideration.

Vui was also concerned around the Youth Health result and enquired whether or not this was related to Covid. Mr Hannant advised that all of those types of screening activity will require catch up activity.

Mr Hannant advised that we do need to reflect on how we support the sector and this will be complex. Improving capacity in Primary Care will be a focus in the strategy, what role the DHB can take in improving capacity in Primary Care. This will be an important focus over the next five years.

Dr Jackson, in response to a question from Apulu, advised that the mortality rate data is always two to three years behind due to a myriad of factors.

4. COVID DEEP DIVE

4.1 Provider Wellness Review

4.1.1 South Seas Healthcare (Lemalu Silao Vaisola-Sefo (Lemalu), CEO; Tagaloa Dr Andrew Chan Mow (Tagaloa), GP/Clinical Director)

CPHAC welcomed Lemalu and Tagaloa to the meeting with a mihi from Robert Clark and a round table of introductions.

Lemalu advised that South Seas was representing the Pacific Consortium at this meeting. He gave apologies for the other CEOs that couldn't be in attendance. He acknowledged the DHB for the work they have undertaken in the Primary Care space around how we can do things differently.

Lemalu gave the committee background in regard to how the Consortium was formed and which providers it was made up of (South Seas Healthcare Trust, Penina Trust, Vaka Tautua and Pacific Homecare).

The Consortium's experience through Covid have highlighted the need for the non-health support that families needed.

Tagaloa spoke to the growth rates in Counties Manukau of Youth and Older People being quite extraordinary and will be a challenge moving forward.

Relationships are crucial. Covid forced primary care providers to work together in order to support vulnerable whanau.

Food, clothing, bills and baby products were the most requested items/concerns/required help with. South Seas could only do so much, so being able to reach more families via their Partners was helpful.

Lessons learnt through the Covid experiences include:
Trust - When we operate with our funders to create a high trust environment we can address local needs and effectively support our families.
Collaboration - When we work together and join up primary and community providers we can provide seamless services that improve outcomes for Pacific people and their family.
Wellbeing - By connecting our services we are able to support the complexity and uniqueness of our families, as well as meet our contractual requirements.
Access - Services can be easy to access and simple to navigate when every door is the right door.
Stories - When we take time to understand the wider needs of our families, we can create meaningful plans of action that are based on their goals and aspirations.
Think and act differently - We can achieve a lot when we think differently and challenge ourselves to find innovative ways to support families.
Agile delivery - We have adopted an agile approach - continuously changing the way we provide our services to better support the evolving needs of our community.

The South Seas CBAC response met the needs of our community, ensuring easy access to COVID-19 testing. We closed in on 10,000 swabs. This is the second highest of all the stand-alone CBACs (without a mobile testing team). We swabbed the highest Pacific population, predominantly residing in South Auckland. We swabbed the most walk-ins of any CBAC. The highest demographic swabbed was the 25-44 age group, reflecting our relatively young Pacific population.

Over half of swabs were for those residing in neighbouring suburbs, reflecting the wide reach of the Ōtara CBAC.

Primary Care couldn't manage if remaining within their own bubble, collaboration was key.

All access was virtual through the lockdown period. South Seas purchased a mobile van in order to safely follow up patients with Long Term Conditions, etc.

South Seas will be launching a telehealth programme as not everyone has data. Moving forward, working differently will be essential. South Seas see internet in the home as a basic need and feel that the Ministry of Social Development (MSD) should add data to their list of must haves in the home.

Lemalu advised that safeguarding the gains made during the Covid period will be important.

CPHAC thanked both Lemalu and Tagaloa very much for the time they spared from their busy work schedules to be here today.

4.1.2 Procare (Lance Norman, Head of Equity and Māori Health Outcomes; Dr Allan Moffitt, Clinical Director)

Dr Moffit advised this will be a different presentation as they will give a PHO/Provider view rather than a Practice view.

Essentially Procare is a PHO that cares, including addressing equity.

Covid 19 key aspects include:
- Full incident response for all 173 practices;
- Homecare Medical Covid line support;
- Virtual Care response;
- Pukekohe Community Based Assessment Centre (CBAC);
- Supporting the DHB on the Regional Incident Response Team;
- National 0800 clinician line;
- Practice financial sustainability;

- Support for Māori, Pacific and Asian communities;
- Psycho-social response and pastoral care for general practice.
- Supported solo GPs throughout Level 4.

Maaori/Pacific heard the message of stay home, stay in your bubble. However, they may have missed the part of the message that also advised going to the GP/hospital if you were unwell. This message needs to be pushed in a better way throughout another lockdown to ensure those that are vulnerable or have a Long Term Conditions can maintain their wellness.

Procare put out 'whanau speak' (English, Maaori, Pacific) information, making it easier for whanau to understand the clinical aspects of Covid.

Procare found that young Maaori mums are scared to immunise their babies due to negative social media information. Equity is even more of an issue for vulnerable whanau post Covid and Procare has a range of catch up activity planned.

In regard to Eldery care, Procare is running a Pilot with practices delivering Flu vax in homes.

As a sector we need to think about the affordability of Data and how this can be worked around.

CPHAC thanked both Dr Moffit and Mr Norman for their valuable time.

4.1.3 Huakina Development Trust (Maria Clarke, Tumuaki)

CPHAC welcomed Ms Clarke to the meeting and was grateful she could be in attendance to provide yet another perspective and share Huakina's experiences.

Huakina's mission statement is to 'unleash the potential of people'.

Ms Clarke advised that Huakina had the following experiences/challenges throughout Covid:
- Manaakitanga – How do we support something no one seems to have answers to;
- PPE, Flu Vaccinations, Paramedics;
- Boundaries & Borders;
- Emergency Response, Pandemic Plan, Pandemic Management;
- Communications Plan;
- The importance of – Virtual & Telehealth;
- Connections.

Ms Clarke said that it was essential to know their community. We talk about equity, but it wasn't like that for whaanau in Pukekohe.

Flu vaccines were not readily available. Huakina had to purchase from outside normal circles in order to help Kaumatua who are the most vulnerable.

Boundaries became an issue when needing to support vulnerable whanau outside the boundaries. Again, connections and relationships were invaluable.

Referral issues included lack of clarity around what services were open and which services were closed.

Some of the challenges managed by Huakina included:
- Drive through Flu Vaccinations
- Kai Security
- Mobilising Community Support
- Working across borders

- PPE Gear
- New relationships
- CTC Station

Huakina's message for the DHB was to see the potential in Pacific and Maaori people. Listen to the people. Listen to the community. Ms Clarke advised that it's important to record the stories as it enables relating to others and what they're going through.

Vui advised that as a DHB it is important to see the all of these presentations so that we can learn and as a system continue to enable to community.

CPHAC thanks Ms Clarke for her vibrant presentation and welcomed her to join them for a cup of tea.

5. RESOLUTION TO EXCLUDE THE PUBLIC

Resolution (Moved: Apulu Reece Autagavaia/Seconded: Dianne Glenn)

That in accordance with the provisions of Schedule 3, Clause 32 and Sections 6, 7 and 9 of the NZ Public Health and Disability Act 2000:

The public now be excluded from the meeting for consideration of the following items, for the reasons and grounds set out below:

General Subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
2.1 Confirmation of Public Excluded Minutes 9 September 2020.	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Confirmation of Minutes** As per the resolution from the public section of the minutes, as per the NZPH&D Act.
3.1 Primary Care - Community Covid-19 Testing Surge Framework 4.1 2019/20 Non-Financial Summary and Targets Not Achieved/Strategy Workshop	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i)) of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]

Carried

This first part of the meeting concluded at 11.45am.

SIGNED AS A CORRECT RECORD OF THE COUNTIES MANUKAU DISTRICT HEALTH BOARD COMMUNITY AND PUBLIC HEALTH ADVISORY COMMITTEE MEETING OF 4 NOVEMBER 2020.

_____

Colleen Brown
Committee Co-Chair

Information Paper
Counties Manukau District Health Board
Chief Executive's Report

Recommendation

It is recommended that the Board:

Receive the Chief Executive's Report for the period 28 October – 8 December 2020.

Prepared and submitted by: Fepulea'i Margie Apa, Chief Executive Officer.

Introduction

This report covers the period 28 October to 8 December 2020. This has been a busy period for CM Health. Following the return to level 1, we have seen an increase in presentations to the hospital and our occupancy has been high, often over 100%. We have been focusing on managing these volumes and ensuring that the patient flow throughout the hospital is working well.

As we approach the end of the year, I want to acknowledge and thank everyone at CM Health for their role in supporting our community and each other in what has been an incredibly challenging year. I feel immense pride in what we have achieved this year despite the difficult circumstances, and this has been a result of a team effort involving everyone in the organisation.

News and events

Historic Pay Equity Agreement

On 30 November an initial agreement was reached between the 20 District Health Boards and the PSA, endorsed by the Government, in a significant milestone towards finalising a pay equity settlement for 8,700 DHB clerical and administrative workers. This workforce is 92% female and the agreement reached is an acknowledgement that it has been historically undervalued. The announcement was made by PSA National Secretary Kerry Davies and the DHB representative, lead Chief Executive, Jim Green.

The initial agreement includes a $2,500 interim lift in pay rates for all clerical and administrative workers who currently receive less than the newly agreed maximum job band rates. These maximum pay rates were agreed between the PSA and the DHB and are available on the TAS website. The uplift will be effective as of 30 November 2020, and will be added to salaries early next year, following ratification of the initial agreement.

The initial agreement also sets out pay design principles for the PSA and DHBs to use in developing a new national pay rate and job band structure. The work programme to develop the national pay rates and job banding structure will contribute to a proposal for a full pay equity settlement by mid-2021. Once the agreement is finalised next year, this will be the first time clerical and administrative DHB staff will be covered by one national pay structure with consistent rates nationwide.

This is excellent news for our clerical and administrative colleagues who make an important contribution to our health services, and represents the strong commitment from DHBs to work with union partners in addressing pay equity.

Te Ranga Ora Timatanga

In October we were excited to celebrate a timatanga at the Te Manukanuka o Hoturoa Marae to mark the beginning of Te Ranga Ora, our new system of care for primary and community services to support people and whaanau living with long-term conditions (LTCs) that is the first of its kind.

Te Ranga Ora is being designed with service users and their whaanau and will be delivered in partnership with Te Manawhenua i Taamaki Makaurau, the primary and community sector, lead government agencies, the Ministry of Health and CM Health. The programme will see the development of comprehensive, culturally-capable services delivered across the Counties Manukau area. There will be a focus on meeting the needs of those living with two or more long-term conditions who are Maaori, Pacific or living in the most deprived areas. We are working with five shortlisted prototype collectives to co-design and plan the new models of care. This process has captured the experiences and learnings of whaanau, creating new understanding and insights from their healthcare journey. This is an investment in the future and an opportunity to bring culturally safe models of care to our community, centred around what whaanau want and need.

South Auckland Social Wellbeing Board

The South Auckland Social Wellbeing Board ("SWB") is hosted by CM Health and involves a range of government and non-government organisations working collaboratively with the community to support children and whaanau, and improve long term outcomes for children. The Board has recently released its 2 year action plan and 5 year strategy.

The 2 year action plan is aligned to the Board's 2 year funding path (June 2020- June 2022) and focuses on 5 pillars, or action areas. The 5 year plan sets out the longer term vision for the SWB, including its key goals and aspiration (attached as appendices).

Some key programmes and initiatives of the SWB include establishing partnerships with local Iwi and NGOs, progressing partnership and Multi-Disciplinary Cross-Agency Team models, programmes to reduce family violence and its impact on children, and progressing the services already established at the Papakura Marae hub.

International Orthopaedic Nurses Week 2020

International Orthopaedic Nurses Week was celebrated by the nursing staff on ward 10 and 11 of Middlemore Hospital in October. The Orthopaedic team acknowledged the significant contribution of the nursing team to specialist care of the people of New Zealand, and the Pacific. The celebration was aimed not only at appreciating the nursing team, but also encouraging their well-being and promoting orthopaedic nursing as a specialism for future nurses. All members of the nursing team, including nursing students, were given self-care goodie bags.

Left: the nursing team on wards 10 and 11

Celebrating Diwali

CM Health celebrated Diwali between 8-14 November with a number of events across the organisation, including a photo and video competition and online sessions with quizzes and prizes. Our chefs in the staff café created a special menu for the celebrations.

Congratulations to the Rapua Te Ao Waiora team for winning first prize in the photo and video competition!

Right: The Matariki Mental Health team celebrating Diwali

Aotearoa Patient Safety Day – Te Raa Haumaru Tuuroro o Aotearoa

On 17 November CM Health marked Aotearoa Patient Safety Day. The theme this year was 'Getting Through Together -Whaaia E Taatou Te Pae Tawhiti'. Patient safety is at the core of what we do, and it was great to see the many activities across the organisation. Activities included webinars, a patient safety expo with stalls and displays, a 'mask-a-rade' challenge where staff were invited to decorate cloth masks to be included in the expo, a music concert in the staff café and a yoga session.

Recognising our orderlies on Pharmacy Orderly Appreciation Day

During October and November, our Pharmacy department celebrated World Pharmacist Day and World Pharmacy Technician Day. The Pharmacy team, in collaboration with Orderly Services, wanted to acknowledge all the work orderlies do in the pharmacy space by providing a timely supply of medicines to patients. They decided to make 10 November Pharmacy Orderly Appreciation Day.

A big thank you to all the pharmacy orderlies for everything you do for patients and whaanau.

Above: The Pharmacy and Orderly Teams

International Day of Radiology

International Day of Radiology was held on 8 November, an annual event marking the day that Wilhelm Conrad Röntgen discovered the existence of x-rays in 1895. To celebrate the day our CM Health Radiology team held a cake bake sale with proceeds going to the South Auckland food bank.

Left: Members of the MRT team

White Ribbon Day

White Ribbon Day is held annually on the 25 November and the aim of the day is to raise awareness of domestic violence. People wear a white ribbon to show that they do not condone violence towards women.

This year our Child Protection Team held a cupcake fundraiser in the hospital foyer with $1000 Koha raised donated to Victim Support.

Above: The Child Protection team with police officers at the cupcake fundraiser

Our People

Local Heroes

We continue to receive outstanding nominations for our Local Hero awards. Our winners for September and October were:

- Taylor Drake-Brockman - Registered Nurse
- Kitty Ko - Asian Health Gain Advisor
- Craig Webster – Social Worker
- Courtney Fepuleai - Public Health Nurse
- Father Maurice Ford- Hospital Catholic Chaplain
- Letau Leilua - Registered Nurse
- Rachael Thompson - District Nurse
- Tafa'i Mataia-Misi – Health Care Assistant

Congratulations to all of the winners and thank you for the incredible work you do for our patients and whaanau. More detail about the winners, and why they were nominated, can be found in Appendix 1.

Awards winners

We are proud to have had a number of our staff recently receive recognition from outside the organisation for their work. A big congratulations to all of these individuals on their fantastic achievements.

Andrew Connolly – Colin McRae medal

CM Health General Surgeon Andrew Connolly was awarded one of the Royal Australasian College of Surgeon's most prestigious awards. Andrew was presented with the 2020 Colin McRae Medal which recognises and promotes the art and science of surgery and surgical leadership in New Zealand, and honours those who have made outstanding contributions.

Andrew is a colorectal surgeon. He was Head of General and

Vascular Surgery at Counties for 13 years. He also served on the Medical Council of New Zealand for nine years, the last four as Chair. He has served on several national committees and published more than 35 scientific papers.

Safaato'a Fereti – Pasifika Futures sponsored Pacific Health and Wellbeing Award, Sunpix Pacific Peoples Award

Our Clinical Nurse Director of Medicine, Safaato'a Fereti, was recently awarded the Pasifika Futures – Pacific Health & Wellbeing Award at the 2020 SunPix Pacific Peoples Awards.

Alongside her role at CM Health, To'a is the Chair of the Nursing Council of New Zealand, and the President of the Pan Pacific Nurses Association. Ahead of the awards ceremony she was filmed on the job at Middlemore Hospital, supported by several members of the Pacific Health Development team.

Te Tohu Hautoa – Courageous Leadership Award

Te Tohu Hautoa recipients are recognised for their contributions to the National Hauora Coalition ("NHC"), for supporting and delivering NHC's programmes and for courageous leadership in reducing healthcare inequity.

This year the award was received by our own Dr Doone Winnata, and Waitematā clinicians Dr Andrew Old and Dr Karen Bartholomew (seen above with NHC Chief Executive, Simon Royal). Together with their teams, they provided staff for the NRHCC (Northern Regional Health Coordinating Centre) and ARPHS (Auckland Regional Public Health Service), supporting the health system and the public health response, including contact tracing and management.

<u>Patient Feedback</u>

October and November have been very busy months for CM Health. I include below some of the feedback received from patients over this time.

TADU

"I wanted to say a huge thank you to all the amazing nurses and doctors in the TADU Post Surgical Unit. I stayed there for three nights .The care I received was superb, the nurses went out of their way to ensure I was comfortable and that I had food, even when the main kitchen had been closed and when I needed a non-chew diet. What an amazing team you have there.

A special thank you to the Maxillofacial surgery team who fixed my broken jaw, I am so grateful for these highly skilled individuals that can do amazing things to return someone to a normal life again, my operation

went very smoothly and the team was great at communicating to me all the way through. You guys are the best, thank you so much. I can't speak highly enough of your amazing team, thank you for everything."

National Burn Centre

"Great care from the nurses especially in their promptness in care, knowledge and expertise. I felt I could trust their abilities. Good patient/nurse ratio which meant prompt patient responding. I felt listened to and important. I felt they made changes when I was upset/unhappy with something. All nurses took time to show interest in me and my case - better care. I asked to be kept informed and to know my schedule and I always received this. Thank you."

Cardiology-MMH

"Very nice nurse, thank you for your service. Very happy nurse Rathi, very polite. Please stay safe."

"Receptionist Fonga was lovely and Lisa Rogerson was absolutely caring and kind and made me feel so at ease. She introduced herself from the get go, took time to print out my Discharge summary and I felt comfortable the whole time."

"I appreciate and thank Rathi today for her service. She was very helpful, informative and very gentle with my echo scan today, the best scan I've had so far. Grateful and appreciate the service Rathi and the rest of the staff provide for myself as well as other patients."

Ward 32N

"This is complementing Ward 33 North, Nurse Dhanya. She was my Mum's nurse on 13 and 14 September. What a pleasant personality she has. She impressed my family and Mum with her caring style and professionalism. I have been in and out of hospital many times but this is first time to come across a nurse of such beautiful nature. She brought such positive vibes which made my mum keep on asking to see her. I wish her the very best in her duties. Counties Manukau hospital should be proud to have this type of diligent staff. I thank Dhanya from my heart for making my mum feel happy. Thank you."

Gastro

"I would like to take this opportunity to share my pleasant experience at MSC when I took my mother to the Bowel Screening Colonoscopy at MSC. My mother's bowel cancer testing kit came back positive and it was stressful to know that it was positive with the testing and going through the dietary requirements from three days prior to the colonoscopy. But the colonoscopy itself was handled very professionally and friendly manner from the staff at SuperClinic team. Also I'd like to make praise to Hannah who organised the booking for us with the follow up calls and support messages. Hannah was the bad news bearer but she was a true professional with the follow ups on time and pure interest in patient's benefits. On the surgery day, all the staff at MSC were kind and friendly and I would sincerely thank and congratulate everyone for the smooth and efficient operations."

Performance Reporting

I attach for the Board's information the metrics that matter dashboard for October 2020 (Appendix 2). Highlights for the period include:

- The planned CT and MRI scan seen by times are steadily improving; approximately 40% since January 2020. This translates to reducing the CT scan wait list from 1975 patients to 700 patients and reducing the MRI scan wait list from 1000 patients to 509 patients;
- The readmission rate in the first year of life for all ethnicities is below the target;
- Faster Cancer Treatment 31 and 62 day rates are trending on target (achieved for Q1, 88% for October);
- Ophthalmology ESPI 2 wait times have improved by 27% since January 2020; and
- An increasing proportion of patients are being discharged by ED geriatricians to the community; 73% in Oct 2020 compared to 35% Oct 2019.

At the time of writing this report, the Ophthalmology Services is lowering access thresholds from 55 to 50. This means that an additional 350 people will receive cataract surgery at CM Health and we are on track to achieve equity with the region. The additional capacity and theatre capacity we have invested in this service is coming to fruition in improved access. I want to pay a special tribute to the team in the Ophthalmology service headed by Dr Graham Reeves, Clinical Head and Danny Wu, Acting Service Manager. Our team have worked hard to achieve this improved access for our communities and we thank them.

Lowlights and areas of focus for the DHB include:

- The percentage of PHO enrolled patients who have been offered help to quit smoking has dropped over the last 4 months;
- The gap has widened between Maaori and other ethnicities for immunisation rates for 8 month olds and 2 year olds. The Funding and Health Equity Directorate are scoping a catch up campaign for Maaori immunisation;
- The time to be seen by General Medicine physicians has increased over September and October; and
- ESPI 2 and ESPI 5 waiting times remain non-compliant in General Surgery and Ophthalmology.

Radiology

During the 28 October Board meeting, the Board noted that CT and MRI scan rates for August were lower for Maaori and Pacific patients and asked for feedback on why this was the case.

We have been reporting performance against the 42 day target for Maaori and Pacific patients since May 2020, and there is some variability across these months which reflects lower numbers of patients in these sub-groups. It is difficult to work out all the details retrospectively but nevertheless it does appear that Maaori and Pacific patients are waiting longer for scans for some months in 2020, including in August. We will need to do further work to investigate the possible reasons for this, including looking at our prioritisation and booking procedures.

As with other departments, there have been issues in 2020 with the need to reschedule non-urgent scans due to COVID-19, and a number of patients declined invitations for scans or did not attend during the

lockdown periods, but at present but we cannot say from our data whether this is a significant contributing factor.

We will continue to monitor this closely and report back to the Board on any further findings and actions. The tables below show the data broken down by ethnicity for September and October.

Month	July	Aug	Sept	Oct	Maaori Sept	Maaori Oct	Pacific Sept	Pacific Oct
CT	82%	83.6%	73%	83%	100%	71%	88%	81%
MRI	61%	66.3%	82%	79%	83%	76%	62%	80%

Adverse Events Annual Report

In December, CM Health will release its annual Adverse Events Report which summarises all the Severity Assessment Code ("SAC") 1 and 2 incidents which occurred during the financial year July 2019 to June 2020. These are incidents where a patient has been seriously harmed during medical treatment. As part of our commitment to patient safety, CM Health now also reports on events where no long lasting harm has occurred, and significant near misses (i.e. where no patient harm has occurred but the potential for future harm from recurrences was apparent).

It's important that these sorts of events are reviewed to determine the underlying cause so that improvements can be made to reduce the likelihood of such events occurring again. We have worked hard to develop and encourage a culture in which staff feel safe to report adverse events, and there were 53 reported during the year. The report, which will be made available on CM Health's website, provides detail on the findings of our investigations, recommendations which have been made and changes implemented.

Appendices:

1. Local Heroes Winners
2. Metrics that Matter Dashboard
3. South Auckland SWB 2 Year Plan and 5 Year Strategy

Appendix 1 – Local Heroes Winners

September 2020

Taylor Drake-Brockman - Registered Nurse

"My mum was an inpatient in the surgical ward after her knee replacement surgery and she was very anxious because family members weren't allowed to stay overnight due to Covid-19 restrictions. Taylor made her feel comfortable and went above and beyond to look after her. Taylor was so kind, that one time she sat on the floor to help mum put on her stockings and cared for her very kindly. She is truly living the values of CM Health for every patient."

Kitty Ko - Asian Health Gain Advisor

"Kitty always goes above and beyond to deliver the best possible outcome for our Asian staff and population. She makes everyone feel included and valued and has a special way of getting the best out of everyone she engages with."

"Kitty is an unsung hero. She single-handedly works with multiple Asian populations, sends emails all hours of the evening, and never once complains. She is always positive and grateful, always rallying for the good of our people, and even bakes for people to say thanks. It's amazing how much she manages to achieve thro ugh all her relationships and is simply irreplaceable."

Craig Webster – Social Worker

"I am currently doing my Social Work placement at Tiaho Mai and Craig has been the student's "go-to man". He has been absolutely exceptional ensuring we have the best experience possible while on placement. He has shown all of CMDHB values and more! He deserves to be nominated continuously for the mahi he does! Thank you Craig, you have been one of the highlights while training in CMDHB."

"Craig has been going above and beyond to support student social workers completing a placement at Counties Manukau Health. Many of us were due to start placement the week after our second COVID-19 lock down commenced. This meant there was a sudden holt in our plans to start. Through the ordeal, Craig's communication with the students, the University, and the Counties Manukau supervisors was exceptional. I feel that his mahi with us must be acknowledged."

"Craig always has time for everyone and makes it a priority to value members of the team. He's a consistent hard worker and is always striving for the best for his team and his patients. My experience here at Middlemore would not be as rewarding without Craig. He goes above and beyond and you know you can trust and rely on him."

"As a Social Work student, I feel that Craig has gone above and beyond to support us through an unsure time. It's not even a role he is paid for, yet he dedicates time and his empathy towards us to ensure that the up and coming social workers are well looked after and set up to have successful placements. He demonstrates all of the values - Excellence, Kindness, Together, and Valuing Everyone."

Courtney Fepuleai - Public Health Nurse

"On Tuesday 1 September, Courtney was working in a seconded role at the CBAC COVID-19 Testing Centre, Mangere. One of the patients visiting the centre for testing collapsed at the wheel of his car, after sustaining a cardiac arrest. Full CPR was required, and the use of a defibrillator was needed to restart this patient's heart. The chance of survival from a community arrest is less than 10%. This patient made it to ICU/CCU and hopefully home by the time this award is made. Courtney took the lead role and performed CPR. She was congratulated by the St John Ambulance crew for an excellent outcome. It was noted that Courtney remained calm throughout the event. Courtney in her humble way immediately acknowledged that this was a team effort."

October 2020
Father Maurice Ford- Hospital Catholic Chaplain

"Father Ford has, in many situations, gone well above his duties when visiting supporting and ministering to the patients and their whaanau/family that we manage at Bereavement Care. Never has he declined to come when called even at night, weekends, or public holidays, when we/whaanau/families have needed his services. He inspires us all to go beyond our limits.

"Father Maurice has worked consistently hard over the past few months, even during part of lockdown. He has attended to all Christian faiths as he has often been the only priest in residence at the time."

"I know many people would join me in recognising him as 'Hero' especially the nurses and doctors who are concerned about their patients especially in the critical care areas of the hospital. His faithful service has been outstanding. "

Letau Leilua - Registered Nurse

"She is a very hardworking Registered Nurse, always arriving at work before time and helping other RNs to setup their dialysis machines. She also assists Health Care Assistants to screen patients and brings them to their beds. She is very caring towards all her patients. Even after dialysis she would take patients back to the ward, reheat their dinner, and serve to patients so that they can enjoy their warm meals. She goes above and beyond to help not only the patients but other colleagues in the unit. Patients are always happy to have Ms. Letau as their nurse."

Rachael Thompson - District Nurse

"Rachael is always at work early, she organises her workload and then offers her assistance to other staff - she is continence resource nurse which takes a lot of her time. Rachael is approachable about any continence issues and she goes out of her way and in her own time to make sure her patients and colleagues are well looked after and supported. Rachael smiles even when her workload is huge and she wonders how she will do justice to all her patients. Rachel doesn't complain she just gets on with things. Rachael is very thorough in her practice and delivery of care. It is a privilege to work with her."

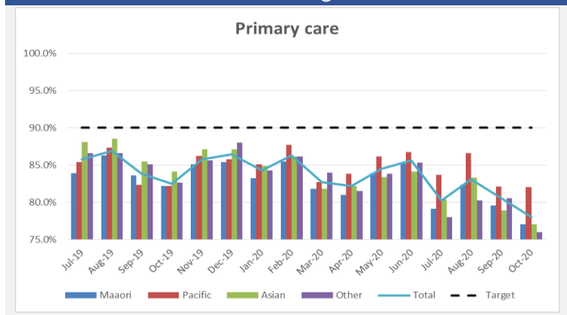
Tafa'i Mataia-Misi – Health Care Assistant

"Tafai is hands down one of the best HCAs within the DHB. She is always working extremely hard no matter what the situation; she goes above and beyond for all our patients and their family. She is always smiling - providing whakawhanaungtanga and manaakitanga to everyone that she interacts with. Tafai is always kind to her fellow colleagues and everyone that visits the ward. If you ask anyone on the ward about Tafai, they never have anything bad to say - she is an extreme treasure and highly valued within the ward. Nothing is ever too much for this fabulous young lady. We literally have to race her to answer the bells and I want her to know how treasured she is. You're a true gem Tafai."

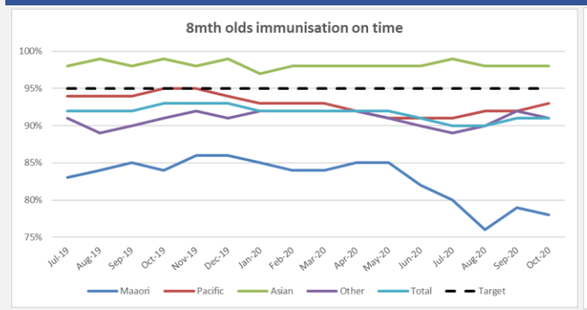
CM Health Metrics That Matter Summary

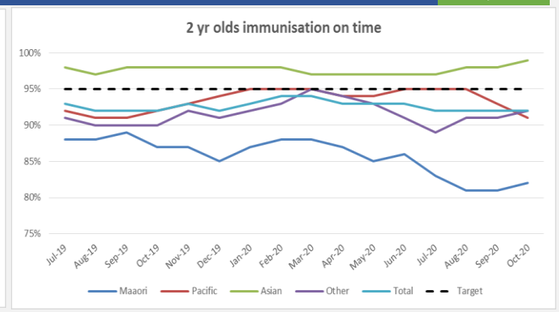
Results to Oct 31 2020

Smoking Cessation

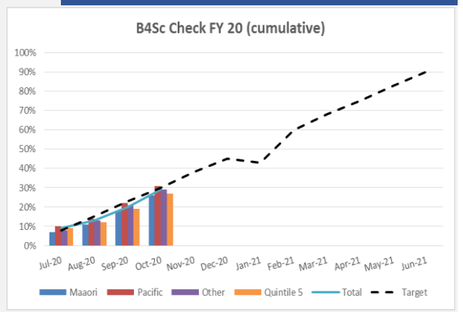


Immunisation Q&S

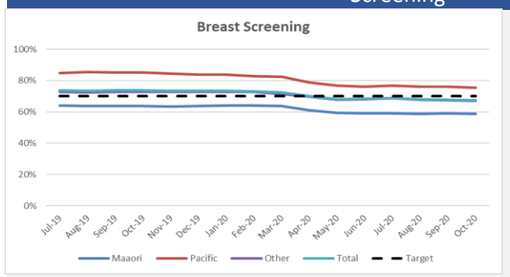


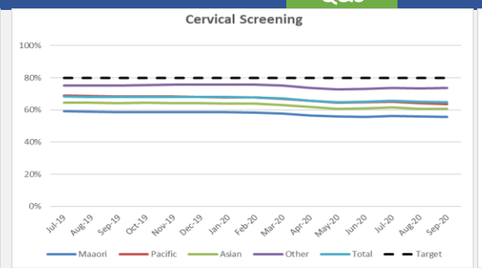


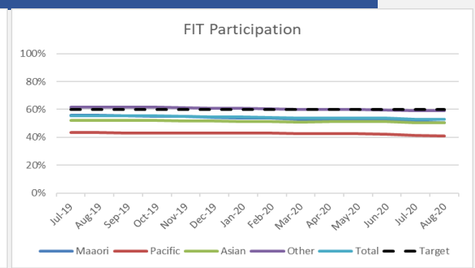
B4Sc check



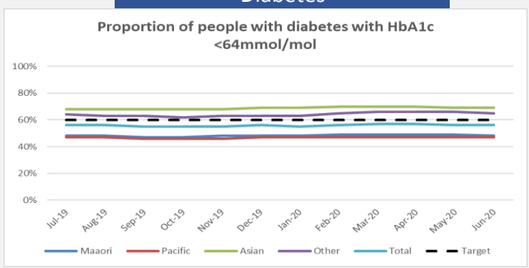
Screening Q&S



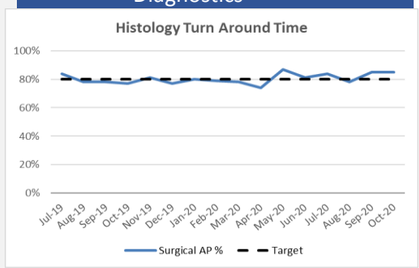




Diabetes

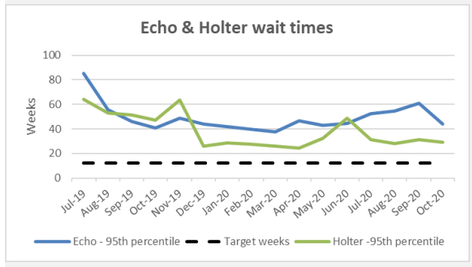


Diagnostics

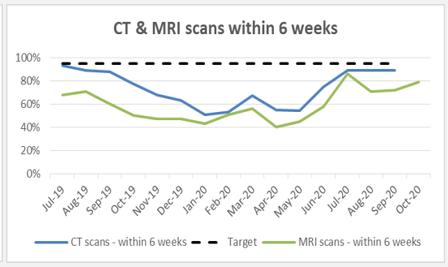


Diagnostics

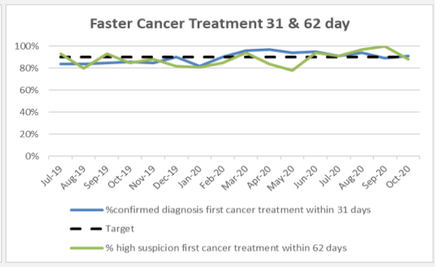
Cardiology



Radiology



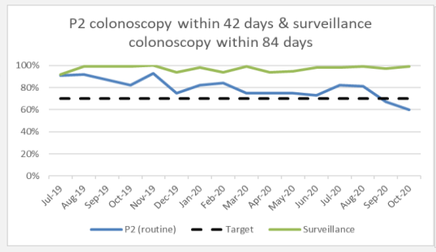
Oncology Q&S

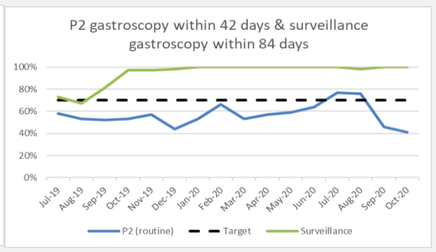


Q&S Gastroenterology Q&S

P1 Colonoscopy & P1 Gastroscopy

100%

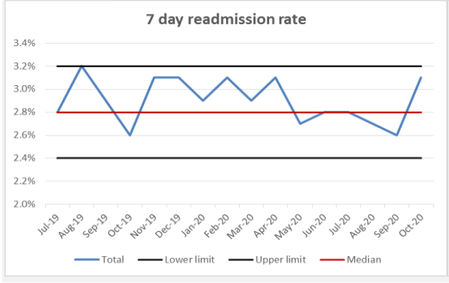


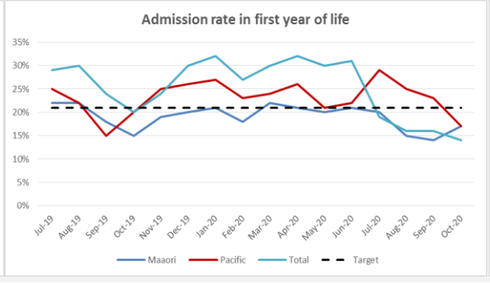


Acute

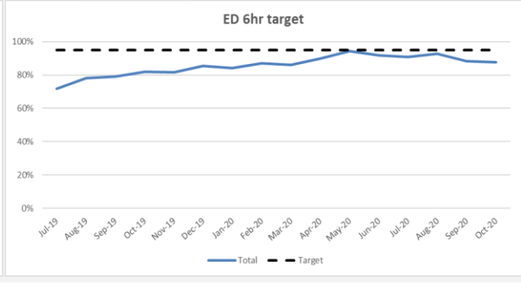
Readmissions

Q&S

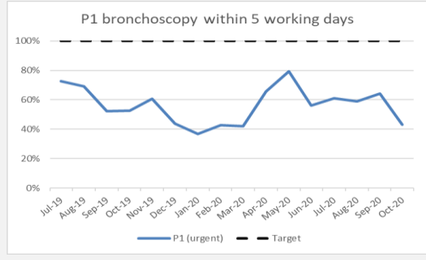


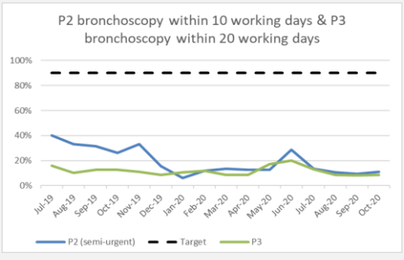


Q&S



Respiratory





CM Health Metrics That Matter Summary

Results to Oct 31 2020

Smoking Cessation

Primary Care

PH04: Percentage of PHO enrolled patients who smoke who have been offered help to quit smoking by a health care practitioner in the last 15 months

Maternity

CW09: Percentage of pregnant women who identify as smokers, at the time of confirmation of pregnancy in general practice or booking with a Lead Maternity Carer, being offered advice and support to quit smoking. Removed for October as data is available at the end of the quarter.

Immunisation

Q&S

8mth old immunisation

CW05: Percentage of eight months olds who have had their primary course of immunisation on time

2yr old immunisation

CW05: Percentage of two year olds who are fully immunised

Influenza

Removed for October as data only collected annually

B4Sc check

B4Sc check

CFA: Completed B4 School checks of 90% of eligible population (7810) **Note:** Plotted is the cumulative achievement per month against the eligible population

Screening

Q&S

Breast screening

Proportion of women aged 50 – 69 years who have had a breast screen in the last 24 months

FIT participation

Participation is the proportion of invited people during a timeframe that were screened.
The numerator is the number of eligible people who have returned a completed FIT kit during the reporting period.

Cervical screening

Proportion of women aged 25 – 69 years who have had a cervical smear in the last three years **Note**: Data reported is one month in arrears

Diabetes

Diabetes

Proportion of people with diabetes who have satisfactory or better diabetes management (HbA1c<64mmol/mol). **Note:** Data is available at the end of each quarter. July - September 2020 has not yet been processed.

Diagnostics

Cardiology

Echo & Holter wait times

% of Echos and Holters completed with 12 weeks of acceptance of a referral

Radiology

CT&MRI scans within 6 weeks

% of scans completed within 6 weeks of acceptance of referral

Oncology

Q&S

FCT 31&62 days

31 day - % of patients waiting less than 31 days from the decision-to-treat to receiving their first treatment (or other management) for cancer.

62 day: % of patients who are treated within 62 days of referral with a high-suspicion of cancer

Histology

% of histology samples completed within 5 working days, from registration in the Laboratory to report ready

Gastroenterology

Q&S

P1 colonoscopy within 14 days

% of urgent colonoscopies performed with 14 days of acceptance of referral

P1 gastroscopy within 14 days

% of urgent gastroscopies performed with 14 days of acceptance of referral

P1 bronchoscopy within 5 days

% of urgent bronchoscopies performed with 5 working days of acceptance of referral

Q&S

P2 colonoscopy with 42 days

% of routine colonoscopies performed with 42 days of acceptance of referral

P2 gastroscopy with 42 days

% of routine colonoscopies performed with 42 days of acceptance of referral

P2 bronchoscopy with 10 days

% of semi-urgent bronchoscopies performed with 10 working days of acceptance of referral

Q&S

Surveillance colonoscopy within 84 days

% of surveillance colonoscopies performed with 84 days of acceptance of referral

Surveillance gastroscopy within 84 days

% of surveillance gastroscopies performed with 84 days of acceptance of referral

P3 bronchoscopy within 20 days

% of P3 bronchoscopy performed with 20 working days of acceptance of referral

Acute

Readmissions

Q&S

7 day readmission rate

The number and % of patients who are discharged and readmitted within 7 days

Admission rate 1st yr of life

% of births from MMH readmitted within the first year of life.

Q&S

ED 6 hr target

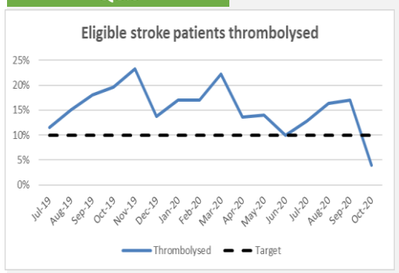
% of patient presentations to the ED with an ED length of stay of less than six hours from the time of presentation to the time of admission, transfer and discharge.

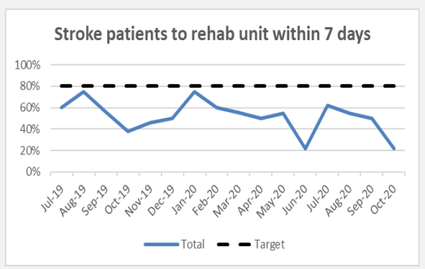
CM Health Metrics That Matter Summary

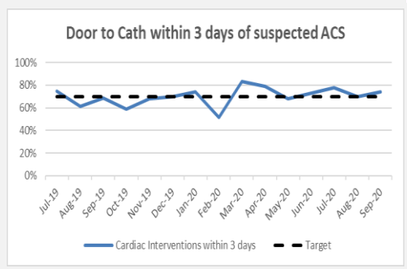
Results to Oct 31 2020

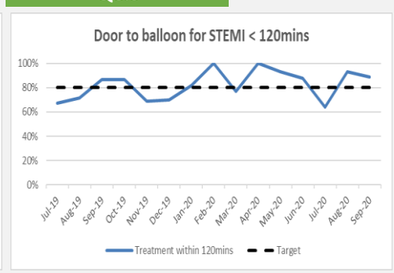
Acute

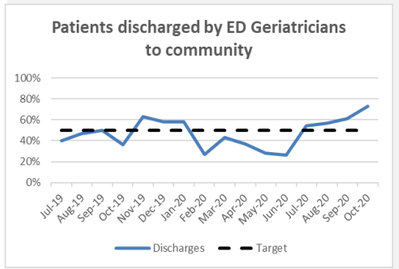
Q&S

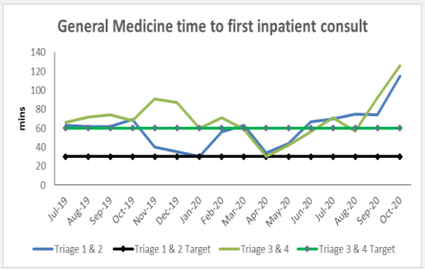


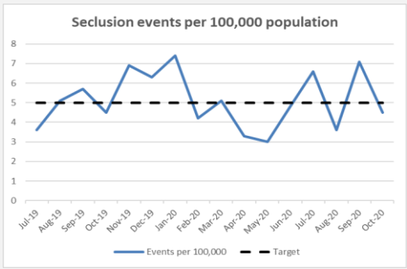






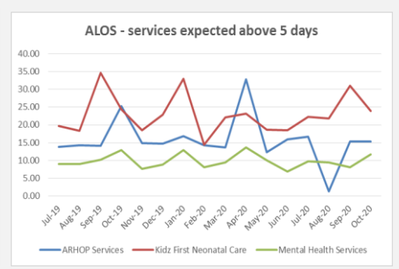


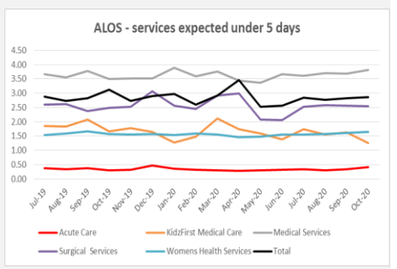




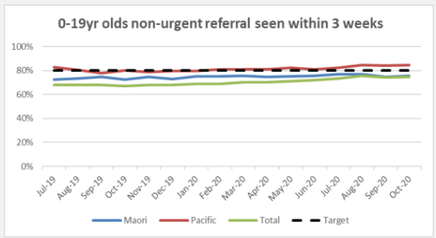
Average Length of Stay

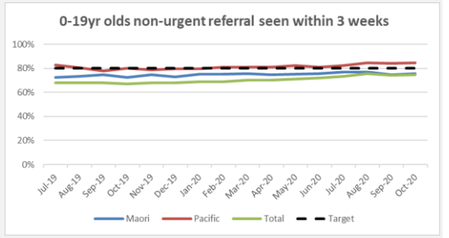
Q&S





Mental health





Planned Care

Waiting time compliance

Q&S

ESPI 2 compliance

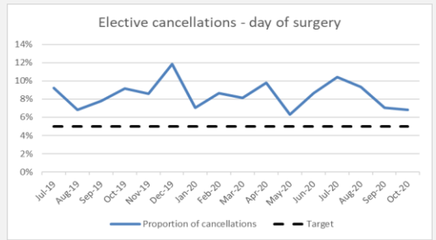
	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
General Surgery	17%	21%	22%	34%	37%	27%	21%	17%	16%
Ophthalmology	34%	35%	32%	38%	38%	35%	18%	8%	7%
Orthopaedics	0%	2%	4%	21%	32%	24%	31%	23%	24%

ESPI 5 compliance

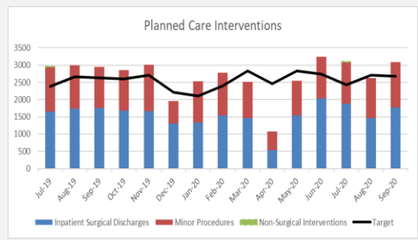
	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
General Surgery	6%	7%	9%	21%	13%	10%	9%	6%	4%	4%
Ophthalmology	2%	2%	7%	13%	16%	10%	5%	2%	1%	2%
Orthopaedics	1%	2%	5%	12%	11%	9%	7%	3%	2%	2%
Plastics	22%	25%	24%	35%	33%	30%	27%	23%	19%	17%

Surgery

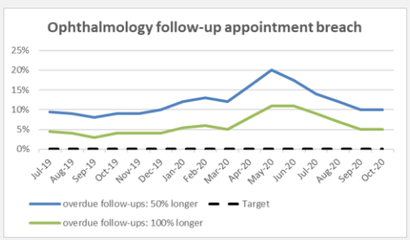
Q&S



Planned intervention

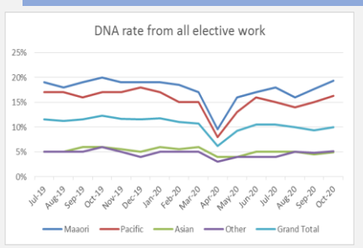


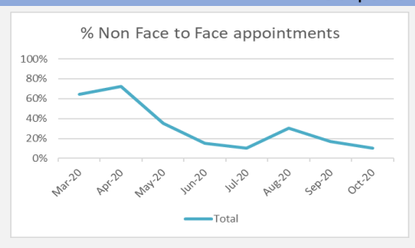
Ophthalmology

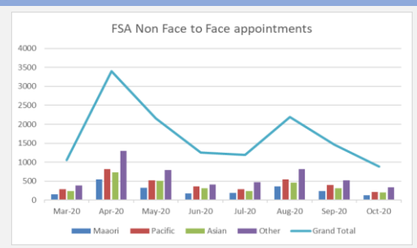


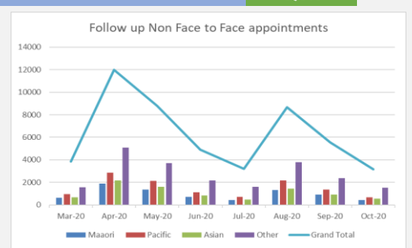
Outpatients

Q&S





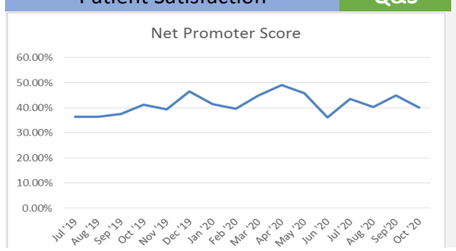




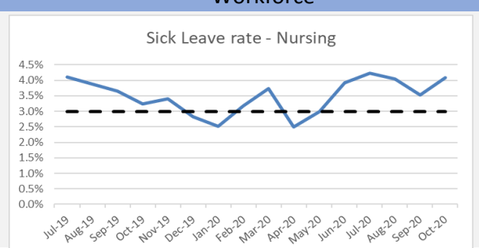
Non-clinical performance

Patient Satisfaction

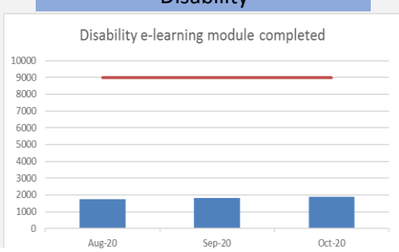
Q&S



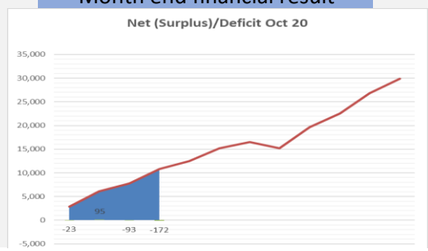
Workforce

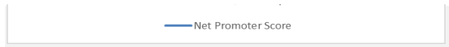


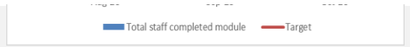
Disability



Month end financial result







Q&S

Eligible stroke patients thrombolysed

% of patients admitted (by admit date) with: admission type of acute; admission method of home/routine; and principal diagnosis of ischemic or non-specified stroke

Stroke patients to rehab unit

Number of patients with an admission for a subsequent rehabilitation inpatient event within 7 days of the acute event's admission date

Door to cath within 3 days

% of inpatients who receive cardiac related angiographic intervention within the Cardiac Cath lab within 3 days

Note: Data reported one month in arrears

Patient discharged by ED Geriatricians to community

% Patients Seen by ED Geriatrics discharged to Community (inc Respite and POAC)(not admitted)

Time to first inpatient consult

1st Time a Triage 1 & 2 or a Triage 3-5 patient attending ED with General Medicine recorded as the first specialty is seen by a physician upon referral (median time in minutes)

Seclusion events per 100,000

The rate of seclusion events per 100,000 where the seclusion period is deemed to have ended when the patient leaves the conditions of seclusion without the expectation of return, and in any case, if the patient has been out of seclusion for more than one hour.

Q&S

Door to balloon for STEMI

% of patients who receive treatment for a ST elevated myocardial infarct within 120mins of diagnosis - performed at MMH **Note:** Data reported one month in arrears

Average Length of Stay

Average Length of Stay

Time from admission to discharge

Alcohol Harm (6mthly)

Removed for October as data only collected 6mthly

Mental health

0-19yr olds referral seen within 3 weeks

% of persons not seen for 12mths or ever, who are referred and have face to face contact with a mental health or addiction professional within 3 weeks **Note: 3mths in arrears, 12mths rolling**

0-19yr olds referral seen within 8 weeks

% of persons not seen for 12mths or ever, who are referred and have face to face contact with a mental health or addiction professional within 8 weeks **Note: 3mths in areas, 12mths rolling**

Planned Care

Waiting time compliance

Q&S

ESPI2 compliance

Elective Service Performance Indicator (ESPI). Number of patients currently waiting longer than 120 days from date of referral for their First Specialist Assessment

ESPI 5 compliance

Elective Service Performance Indicator (ESPI). Number of patients currently waiting longer than 120 days for treatment – elective

Surgery

Q&S

Elective cancellations - day of surgery

Planned intervention

Planned Care Interventions

Number of planned care interventions against agreed service delivery **Note: 1mth in arrears**

Ophthalmology

Ophthalmology wait times

% of patients who wait longer than 50% and 100% of the intended time for their follow up appointment

Outpatients

Q&S

DNA rate for all elective work

% of patients who did not attend their First Specialist Assessment (FSA) or who did not attend their second or more assessment for the same referral (excludes ED and Procedures)

% Non Face to Face Appointments

% of outpatient appointments which are conducted without the patient being physically present as a proportion of all appointments

FSA Non Face to Face appointments

Volume of First Specialist Assessments which have occurred without the patient being physically present (recorded as Telephone, Video Conference, Non Patient Contact in iPM)

Follow Up Non Face to Face appointments

Volume of Follow up assessments which have occurred without the patient being physically present (recorded as Telephone, Video Conference, Non Patient Contact in iPM)

Non-clinical performance

Patient Engagement

Q&S

Friends & Family Test

Net Promotor Score

How likely are you to recommend our service to friends and family if they needed similar care or treatment?

Workforce

Sick Leave rate - Nursing

Sick leave hours in the month divided by total hours in the month expressed as a %. **Note: Nursing chosen as staff group with most robust data available**

Disability

Disability e-learning module

% of staff who have completed the disability e-learning module. **Note: Denominator is all staff as this is part of mandatory training**

Month end financial result

Net result

Actual operating expenditure against budget across CM Health

Appendix 1.
5-year strategy & 2-year work plan

South Auckland Social Wellbeing Board 5-Year Strategy (2020 – 2025) and 2-Year Action Plan

Contents

The South Auckland Social Wellbeing Board (as at June 2020)

Independent Chair
Sandra Alofivae

Advisor to the Chair
Lewis Holden (State Services Commission)

Accident Compensation Corporation:
Neil Phillips

Auckland Council:
Gael Surgenor

Counties Manukau DHB
Margie Apa

Department of Corrections
Alistair Riach

Kainga Ora
Karen Hitchcock

Ministry of Education
Isabel Evans

Ministry of Health
Clare Perry

Ministry of Justice
Julia Lynch

Ministry of Pacific Peoples
Sina Aiolupotea-aiono

Ministry of Social Development
Mark Goldsmith

NZ Police
John Tims

Oranga Tamariki
Glynis Sandland

Te Puni Kokiri
Martin Mariassouce

Purpose of this document

Engage Others
in the diversity, equity challenge and opportunties in our community

Our community is diverse and vibrant with strong cultural values. We need to leverage the strengths and work better together at all levels to achieve sustainable future change

Achieve Mandate
to do what it takes to make a difference for our children & whānau

We need agency mandate at all levels to enable our local leaders to do what it takes to make a difference for our communities

Ensure Commitment
to break down the barriers & disrupt the system where required

As a Board we are committed to breaking down the barriers and disrupting the parts of the system that aren't working optimally for our community

Introduction

The next 5 years – building on the work to date

The development of this 5 year strategy and 2 year action plan is intended to create a shared medium term vision, and to identify the actions required to achieve the 5 year goals. There is a deliberate shift to a "next phase" view for the SASWB, building on the cross-cutting themes from learnings to date. The 2 year action plan is aligned to the confirmed 2 year funding path, including the Joint Venture for Family Violence and Sexual Violence (JV) funding for early years family violence initiatives.

Factors impacting our community in the next 5 years

The Board has identified a number of factors that will impact our local environment, and therefore the role and function of the SASWB over the short-medium term, including:

- An increased agency focus on relationships with Iwi and NGOs, and enabling communities to take active roles
- A strong focus on partnerships, prevention and participation, however, at the same time, acknowledgement of an increase in intensive support models that are currently operating within single agency silos
- Agencies' operating models are evolving, building on learnings from the COVID response, and include a general shift by the majority of agencies from central to local / regional decision making
- The COVID recovery response. There will be a significant impact in South Auckland, particularly on unemployment, housing, financial security and the resulting psychological distress and trauma. There is an exacerbation of existing stressors for already at risk families, but also a population cohort who have never required support before now accessing support. The Board considers it has a role to play in supporting South Auckland's COVID recovery phase
- The social housing building programme (volume and density) will have an impact on the ability of existing infrastructure and supporting services including schools to meet the needs of a growing and potentially vulnerable population.

There is a consensus that the impact of these factors in the medium term will benefit from enhanced collaboration, a specific focus on communities of greatest need, and a wellbeing strength based approach.

Our journey to date and the shift to the next phase

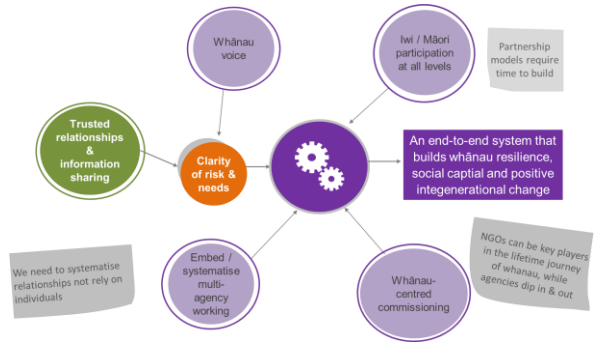
Since its inception in 2016, the SASWB has applied a whānau-centred early support and prevention approach to improving long term outcomes for children. The original '5 intervention settings' have evolved over time, to testing initiatives across the spectrum of prevention, crisis and building whānau resilience. We recognise the unique features of our community, the local nuances and the need to understand the complexities and growing inequity for our Māori and Pasifika populations. The ongoing refinement of the PBI infrastructure, governance and management arrangements, and the backbone function over time, has enabled the SASWB to test and learn rapidly, and therefore respond in a timely way, to community needs as a collective, when required.

Building resilient communities through greater collective impact

The SASWB's member agencies have collectively been on a journey of mindset change, contributing to the design of different ways of working that use evidence and insights to achieve greater collective impact. There is still more work to do to integrate the culture change throughout the member organisations, and this will be a key piece of work in the 2 year action plan.

Agencies have achieved a significant shift on the spectrum from networking / co-ordination as a group, where information was exchanged for mutual benefit, to an advanced level of co-operation and collaboration where there is now some common planning, formal communication flows and some resource sharing and concessions. The SASWB is on the cusp of being able to achieve greater collective impact and an end to end system; a system that will support and enable communities to build social capital, whānau resilience and long term intergenerational change. The key elements required to achieve this are highlighted in Figure 1, and work on these elements form the foundation of the Board's 5 year strategy.

Figure 1: Key elements to achieve greater collective Impact and an end-to-end system



There is more work to be done to make a long-term difference through evidence-based disruption

Long term sustainability continues to be a key driver of the SASWB's strategy.

Embedding the collaborative way of working into core business, and formalising iwi and community partnerships will enhance our ability to respond to the consistent theme across all SASWB prototypes; that there is a high complexity of underlying stressors for a large proportion of South Auckland families, and systems are currently disproportionately accessible to those that do not require them the most.

The strategy and action plan will reinforce the test and learn approach but will also incorporate an intent to act on its mandate to disrupt where necessary to achieve outcomes for whānau. There will be support for agencies to identify and implement core business improvements that are gained from improved collaboration; inform system level change; and to break down organisational barriers and silos.

We will continue to support and work in partnership with other PBIs and across Tāmaki Makaurau to create an environment that supports and enables protective factors in communities; share learnings; and present national themes for system level change.

What we know: There are many opportunities to make a real difference for children and whānau

Our 5 year strategy builds on our strengths, and the opportunities we have identified, that will continue to strengthen the effectiveness of the SASWB's collaborative way of working to achieve improved outcomes for children and whānau.

The 2 year Action Plan specifically incorporates mitigation strategies to address known weaknesses and threats that limit our ability to achieve our goals.

Strengths

- Agency commitment, passion and investment in South Auckland
- Effective collaborative / local infrastructure established through building of trusted relationships and mindset evolution over time – and a recognition that this takes time
- Deep understanding of South Auckland community, the complexities of its unique population groups & challenges
- A willingness to challenge the status quo and tackle what is often considered as "too hard"
- An Independent Board Chairperson
- Ability to incorporate strategic and operational insights
- Relationships functioning well with proven deliverables
- Diversity across agencies
- An agile backbone function / Implementation Office
- Focus on achieving a whānau-centred approach
- A common purpose driven by shared culture and vision & ability to influence and challenge each other
- A testing / learning framework underpinning design and delivery

Weaknesses

- Funding uncertainty – resulting in lack of staff security / consistency
- Decision making at local level being impacted by centre
- Different governance arrangements across agencies, and a lack of regional autonomy for some who then cannot fully participate in SASWB activity and/or local decision making
- National barriers – national policy influencing local ability to exercise discretion and therefore a tendency to err on the side of caution locally
- Ability to navigate complexity of Manawhenua and Matawaka in South Auckland
- Ability to respond to the complexity within the Pasifika community
- Currently a government agency focus only with no Iwi / Māori/ community input at governance level

Opportunities

- Shift to a focus on wellbeing rather than deficits
- Embed learnings and performanceimprovement opportunities into agencies / system
- Systematise established trusted relationships across agencies
- Iwi / community voice at the table
- Build community relationships and partnerships that 'live' the the Treaty partnership approach
- Better define whānau
- Springboard off COVID-19 operating model enhancements
- Align with other Auckland regional initiatives for impact (APO, ASSLG, Regional Public Sector Lead)
- Connect and share learnings with other PBIs and NGOs
- Resource investment in Auckland region
- Increase visibility of learnings in Wellington
- Mandate for disruption

Threats

- Risk aversion & organisational inertia
- Scale and complexity of South Auckland – risk of being put in the "too hard" basket
- Reprioritisation of collaborative resources back into agencies at discretion of individual agencies
- The need to continue to prove 'legitimacy' to ensure longevity
- Pace of change limiting communication / real engagement with communities
- Limitations on local mandate and flexibility from centre

What we know: We need to work differently to be able to respond to the diverse and complex needs of our community

SWB SOUTH AUCKLAND SOCIAL WELLBEING BOARD

Strong cultural values and unique needs

Counties Manukau

- 16% Māori
- 21% Pasifika
- 27% Asian

40% of total CM population is born overseas

As a % of NZ's

- 11% of NZ's total Māori popn resides in CM
- 37% of NZ's total Pasifika popn resides in CM
- 20% of NZ's Asian popn resides in CM

Access to support is impacted by size and inequity

- 569,000 people = 11% of NZ's population
- Our population is increasing by at least 1-2% every year
- 22% of our population are children = 13% of all children in NZ
- Māori (36%) and Pacific (32%) populations aged <15 years ismuch higher than other ethnic groups
- 205,000 people (36%) live in the most socially deprived areas
- 1 in 2 children live in the most socially deprived areas

It is complex, but we *need* to do better…

- On average, we receive more than **60 Police 111 calls every day** relating to family harm
- 1 in 10* adults receive care for a diagnosed **mental health** condition
- Almost 70,000 people live with one or more **long term health conditions**
- Almost **20,000 people in South Auckland receive Job Seeker** Income Support (43% of the total for Auckland)
- A further **18,500 people receive other income support**
- Over **2,500 families are waiting for housing** on the Social Housing Register
- **55% of students** in Counties Manukau were attending school regularly in T2, 2019 (c.f. 59% for all of Auckland)
- On average, **175 ROCs are received by OT every week**
- **1,086 school age** children are not attending school
- **4,220 'unique' children aged 0-4 years** were present at one or more family harm call outs in a 12 month period. The weekly volumes increased over lockdown. (Fig 2)

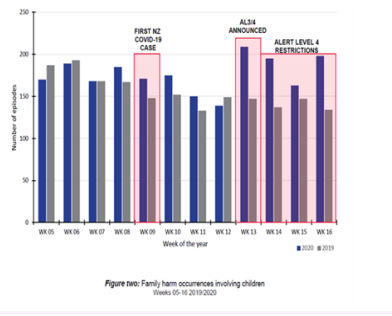


Figure two: Family harm occurrences involving children

- We have the **highest number of child protection referrals nationally** with over 1,000 per year

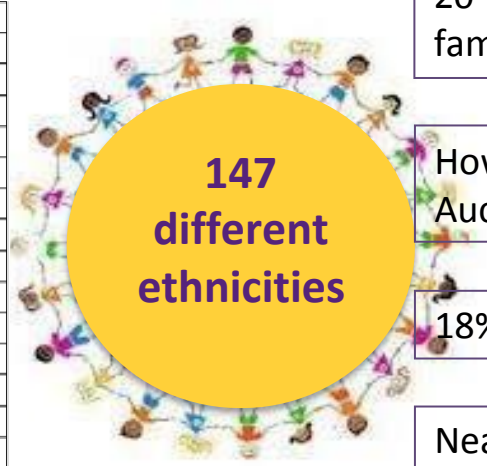
* This rate is potentially impacted by lower than expected access rates for some populations

What we know: The South Auckland community is diverse and vibrant, with strong cultural values... these strengths are core to building resilient communities

83% of those of Māori descent identified with **one or more iwi**

Iwi or waka/iwi confederation	Number
Ngāpuhi	24,030
Waikato	9,350
Ngāti Porou	5,760
Ngāti Maniapoto	4,550
Tūhoe	3,260
Ngāti Kahungunu (various)	3,050
Te Rarawa	2,920
Tainui	2,890
Ngāti Tūwharetoa	2,740
Ngāti Whātua	2,520
Te Arawa	2,150
Ngāi Tahu / Kāi Tahu	1,900
Ngāti Kahu	1,800
Ngāti Awa	1,730
Te Aupōuri	1,640

2013 Census



One in four people in **Papakura (28%) and Manurewa (25%) identify as Māori**

Approximately half **(51%) of the Pacific population identified as Samoan,** nearly a quarter as Tongan (23%) and just over a fifth (21%) as Cook Island Māori.

Younger age groups consist of higher proportions of Māori, Pacific and Asian peoples

20-30% of Māori, Asian and Pacific people were in **households** that included other family householders compared with 6% of NZ European/Other groups

Howick has the highest proportion (49%) of the population **born overseas** in the entire Auckland region. Ōtara-Papatoetoe also has a high proportion (42%)

18% of those who had been born overseas had been living in New Zealand <5 years

Nearly two-thirds of people in **Māngere-Ōtāhuhu identify as Pacific (61%),** alongside almost half of the people in Ōtara-Papatoetoe (46%) and one-third of the people in Manurewa (33%)

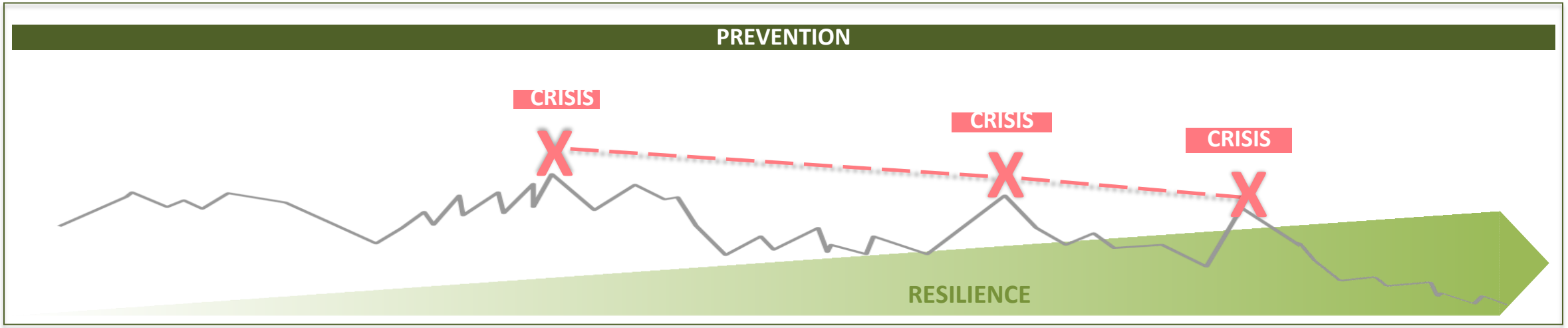
Nearly half of the Asian population in CM Health identified themselves as **Indian (46%) and a third as Chinese (34%).**

The Middle Eastern, Latin American, African **(MELAA) group represents 1.4%** of the CM population; 64% of this group identified as Middle Eastern

Our strategic aspirations and success factors

In 5 years time, we will be able to say....	We will know we've succeeded when....
1 Children and whānau are leading the development of their own "one plan" and they trust us to support them	1 Our systems are able to flex up and flex down and respond to the goals and aspirations of whānau
2 We are working in partnership with Iwi	2 There is an agreed definition of partnership and thereis mutual trust and confidence
3 Collaboration across government and non-government organisations is the way of working	3 Agencies initiate collaborative working because it improves whānau outcomes, and adds value to the way that they are able to respond to whānau
4 Our frontline workers *want* to work in a multi-disciplinary environment	4 Multi-disciplinary working is seen as a professional development opportunity and pathway. Trusted relationships are not dependent on individuals.
5 NGOs are enabled to take the lead in supporting communities of greatest need and whānau to build long term resilience	5 NGOs are funded in a way that enables them to walk alongside whānau and feel supported by agencies when they require their support

A system view of prevention, crisis and resilience building as an end-to-end process is fundamental to being able to achieve our aspirations



Current 2018/19 work programme

- Start Well
- ECE Play 30
- School alert
- School alert
- School alert
- School psychological response
- MDCAT
- MDCAT
- MDCAT
- Papakura One Plan Kaiarahi
- FGC and New Mums prevention opportunities

South Auckland Social Wellbeing Board 5-Year Strategy

Why
Why we do what we do

Te Tiriti o Waitangi

Kāwanatanga	Tino rangatiratanga	Oritetanga	Wairuatanga
Decision making	Partnerships	Equity	Spirituality & Values

Child & Youth Wellbeing Strategy aspiration
"That NZ is the best place in the world for children and young people"

What
What we need to do

South Auckland Social Wellbeing Board Vision
All children in South Auckland are healthy, learning, nurtured, connected to their communities and culture, and building a positive foundation for the future

Goal 1: Whānau wellbeing & resilience	Goal 2: Iwi partnership & participation	Goal 3: Collaboration	Goal 4: Equitable access
Mana motuhake Children & whānau determine their own journey	*Rangatiratanga* Iwi partnerships & participation at all levels	*Manaaki ki te tangata* A collaborative way of working is embedded as core business	*Tomonga Matatika* Diverse communities of greatest need including Māori and Pasifika are supported and enabled

How
How we will do it

Achieve equitable whānau-centred commissioning that enables whānau voice, and Iwi and NGO leadership

Establish iwi leadership in governance and local community partnerships

Embed an end to end collaborative way of working across prevention, crisis and resilience building

Key Pillars

Resilient communities built on self determined need and strengths; that flourish within environments that support and enable protective factors

Devolved funding models that promote equity and facilitate a one-plan approach

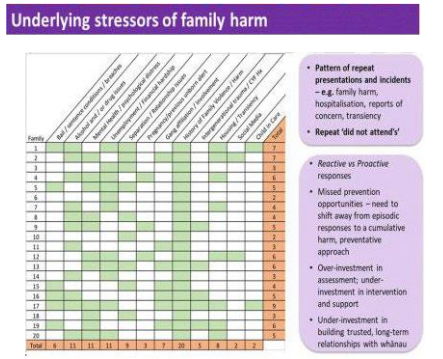
A flexible system of proportionate universalism that reflects the diversity of Counties Manukau

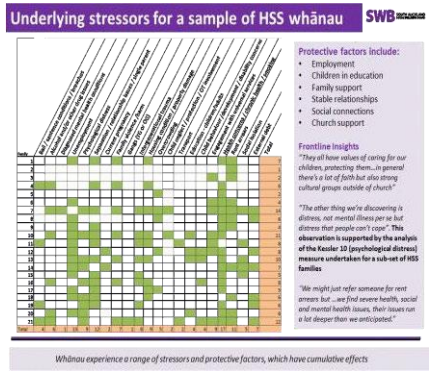
Workforce capability and a 'can do' culture that responds to communities

Collaborative ways of working including NGO leadership focused on whānau defined aspirations

Why are we doing this: We know we can do better for our community

We know there is consistency in the type and complexity level of stressors impacting at-risk families in our community, irrespective of entry point or agency lens. This level of complexity can mean that whānau have limited bandwith to take proactive action to seek / access support.





Impacts of COVID

start well MĀNGERE

The stressors impacting our at-risk whānau

- Psychological distress / mental health
- Hx of family violence
- Alcohol & drug use
- Financial stress/ unemployment
- Housing

→ Inequitable access to universalservices

→ Repeat presentations for support @ crisis

→ DNAs, Missed appointments

\+

COVID has resulted in:

1. An existing population of already stressed becoming more stressed
2. A large cohort of 'new' people seeking support
3. "Hidden" impacts from delayed access to support and care during lockdown

Why are we doing this: We know we can do better for our community

Our whānau, community, and frontline staff have told us that we need to build trusted relationships, and what can be achieved when these relationships are built

"We knew you would help us because last time when it was really bad you were there for us"

"MDCAT is ***the*** way of working".. *Frontline staff*

"You always have my back..."

"The network between agencies in MDCAT helps me to gain quick response in support of the victims/referrals that come through to our agency"..... *Eastern Womens Refuge*

FV victim

- Feel safe – knowing (and being updated on) the process underway for TPO and Parenting Order.
- Happy with the agency contact including EWR, Police, Corrections – felt well supported and heard. Open communication.

"Thank you for sitting down and taking time to talk to me... others don't do that"

FV perpetrator

"It was really awesome to get your call and you listened to me... I still feel really guilty about what happened". Has now made an appointment with Counsellor and stated that he really wants to get a job. Really needs family and support around him as they know how to keep him under control when triggered.

Executing the strategy: The 2-Year Action Plan

New pieces of work | New Prevention Opportunities | In progress | JV = Joint Venture

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ACTION AREAS	PILLARS				
	Resilient communities built on self determined need and strengths	**Devolved funding** models based on need	**A flexible system** of proportionate universalism	**Workforce capability** and a 'can do' culture that responds to communities	**Collaborative way of working** incl NGO leadership
Papakura Marae Hub	• Progress development of a community partnership model • Prototype Papakura Marae "One Plan, One System Kaiārahi" (commence 1 July 2020)	• Test a devolved funding approach across all funders with existing contracts / funding	• Design and test an integrated IHV / MDCAT model - building on Papakura Marae Family Start and Well Child services JV		• Design and test a multi-disciplinary "intensive case management" function -- drawing on / streamlining existing agency ICM resources
Early years resiience	• Complete 2.5 years of the 5year Start Well cohort • School alert psychological response • Finalise E&I school alert analysi inform expansion JV		• Design and test a prevention opportunity for at risk mums and new-borns referred from SAM. Integrating Intensive Home Visiting and MDCAT learnings to test a flex up / flex down model JV		• Design and test an integrated Social Work / Health model for a cohort of children requiring FGC intervention. Aligned with OT Intensive Intervention / Edge of Care Model JV
Multi-Disciplinary Hub	• Supporting the COVID recovery response by enhancing the CM MDCAT to respond to increased psychosocial distress (TBC)			• Finalise implementation of MDCAT with Multi-agency Hub	• Test site for elements of the ICR including the new integrated information system (Whetu)
Partnerships	• Establish an Iwi partnership at governance and management levels	• Test a collective commissioning approach building on the NGO Coalition		• Establish and embed Change Champions within agencies	• Continue to build relationships with relevant agency initiatives and programmes
Workforce				• Establish cross organisation training schedule • Scope and test transdisciplinary working	
Evidence & Insights	← Extract and present cross-cutting themes to inform future design and system change →				
Board & SMG	← Take a future focus, and commit to resourcing agreed work programme, break down barriers, and influence internal agency system change →				

Executing the strategy: Accountabilities

SWB SOUTH AUCKLAND SOCIAL WELLBEING BOARD

	Action Area	Lead Agency	Participating agencies	Implementation Lead
Papakura Marae	• Prototype Papakura Marae "One Plan, One System Kaiārahi" (commence 1 July 2020)	NZ Police	OT, MSD, NZP, CMDHB, KA, Corrections	TBC
	• Progress development of Papakura community partnership model	Papakura SG	OT, MSD, NZP, CMDHB, KA, TSI, Corrections, MOJ	Jaymee Wells
	• Test a devolved funding approach across all funders with existing contracts / funding	TBC	TBC	TBC
	• Design and test an integrated IHV / MDCAT model building on Papakura Marae Family Start and Well Childservices	OT, CMDHB	OT, MSD, CMDHB	TBC
Early Years Resilience	• Design and test a multi-agency "intensive case management" function -- drawing on / streamlining existing agency ICM resources	TBC	TBC	TBC
	• Complete 2.5 years of the 5 year Start Well cohort	CMDHB, OT	MSD, OT, CMDHB	Rochelle Bastion
	• Progress school alert psychological response • Finalise E&I school alert analysis to inform expansion	MOE, NZ Police	MOE, NZP, DHB	Ishani Gupta
	• Design and test an integrated Social Work / Health model for a cohort of children requiring FGC intervention. Aligned with OT Intensive Intervention / Edge of Care Model	OT, CMDHB	OT, CMDHB	Ishani Gupta
	• Design and test a prevention opportunity for Mums and new-borns referred from SAM. Integrate Start Well nurse and FSM Social Worker into the collaborative way of working	OT, CMDHB	OT, CMDHB, Corrections	Ishani Gupta
Multi-agency hub	• Finalise implementation of MDCAT with Multi-agency Hub	Hub SG	OT, MSD, NZP, CMDHB, KA, Corrections	Peter Anderson
	• Test site for elements of ICR model including new integrated information system (Whetu)	NZ Police / JV		TBC
	• Supporting the COVID recovery response by enhancing the CM MDCAT to respond to increased psychosocial distress(TBC)	CMDHB / MOH	TBC	TBC (CMDHB?)
Partnerships	• Continue to build relationships with relevant agency initiatives and programmes that support and enable SASWB work	ALL	ALL	IO
	• Test a collective commissioning approach building on the NGO Coalition	JV	TBC	TBC
	• Establish an Iwi partnership at governance and management levels	TPK	ALL	Katrina Taupo
Workforce	• Establish and embed Change Champions within agencies	SMG	TBC	TBC
	• Establish cross-agency / NGO training schedule • Scope and test transdisciplinary roles	TBC	TBC	Seema Kotecha

Executing the strategy: 2020/2021 Work Programme

SWB SOUTH AUCKLAND SOCIAL WELLBEING BOARD

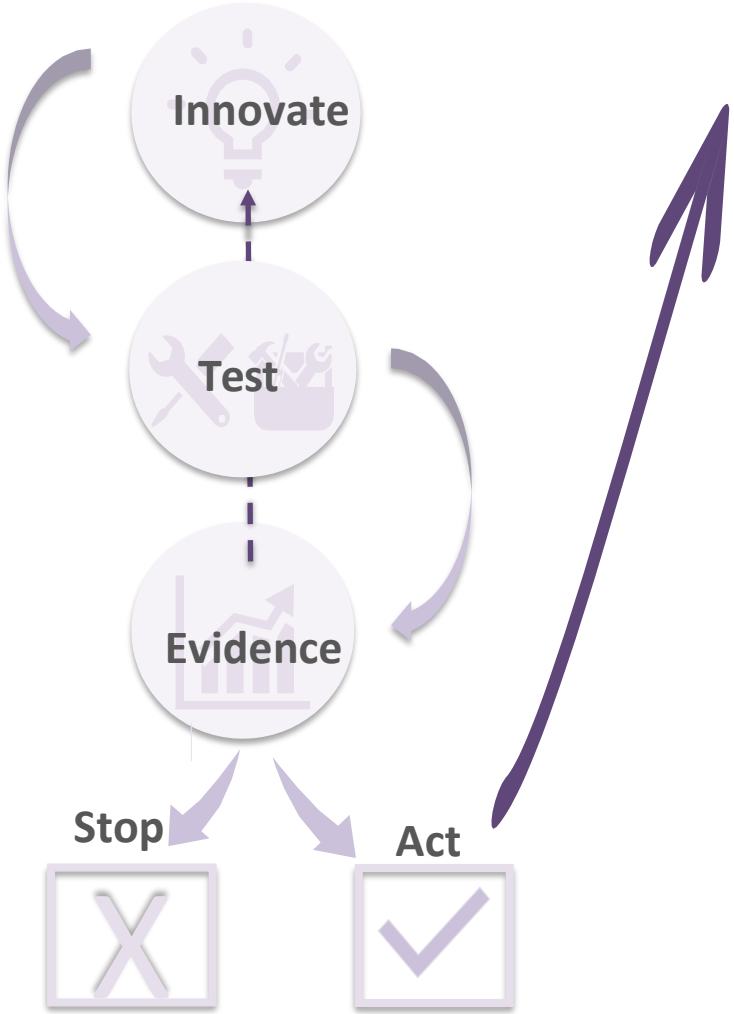
Planned deliverables	Papakura Marae Hub	Early Years Intervention	Multi-agency hub	Partnerships	Workforce
Q1 Sept 2020	• Commence System Navigator • Progress community partnership model • Scope integrated IHV / MDCAT model • Initial workshop for Intensive Case management prototype	• Progress Start Well 5-year cohort • Completion of E&I output for School Alert to inform next steps • Design and planning for school psychological response • Scope and design FGC intervention model	• Transitioned to full operations with confirmed agency participation • Appoint Operations Manager (permanent) • Identify lead for COVID recovery Psychosocial Mental Wellbeing Plan & commence planning (TBC)	• (Refer Intensive Case Management initiative) • Scoping Collective Commissioning approach building on NGO Coalition • Strategic Māori advisors develop an engagement strategy with iwi and Māori	• Workshop to design Change Champion roles / functions • Stocktake workforce training • Scope the transdisciplinary role and how this could be shared across organisations
Q2 Dec 2020	• Implement integrated IHV / MDCAT prototype • Detailed design and planning for Intensive Case Management prototype	• Commence implementation of school psychological response • Implementation planning and commence delivery FGC intervention • Scope integrated IHV / MDCAT intervention for new mums	• Participate in planning of Whetu testing • COVID recovery Psychosocial response in place (TBC)	• Implementing Collective Commissioning • Strategic Māori advisors implement the engagement plan with iwi and Māori	• Commenced implementation of Change Champions within 1-2 organisations
Q3 Mar 2021	• Scope devolved funding approach across all funders (existing contracts) • Implement Intensive Case Management prototype	• Implementation planning integrated IHV / MDCAT intervention for new mums	• Whetu test site	• Strategic Māori advisors co-design an iwi partnership plan	• Share learnings of Change Champions to roll out further • Some shared training sessions in place
Q4 Jun 2021	• Complete System Navigator prototype and share learnings • Learnings from IHV / MDCAT prototype to inform system design • Commence devolved funding model implementation • Community partnership model aligned with strengthened iwi partnership	• Implemented school psychological response with learnings • FGC initiative underway informing Intensive Intervention / Edge of Care model • Commenced IHV MDCAT intervention for new mums	• COVID recovery Psychosocial response fully implemented – learnings to share (TBC) • Multi-disciplinary hub implementation and delivery learnings shared	• Learnings from Collective Commissioning being collated • Strengthened iwi partnerships	• A workforce capability plan

Executing the strategy: Our commitment to innovate and disrupt

Principle driven design

1. Achieve equitable access for our community
2. Incorporate whānau voice into design and delivery
3. Promote leaderful practice that places respectful and trusted relationships at the heart
4. Promote Iwi, community and NGO leadership
5. Optimise and enhance existing services not duplicate or create new services
6. Enable flexible approaches that reduce fragmentation and duplication and enable thriving whānau
7. Responsibility to respond to issues arising in our community in a timely manner e.g. COVID
8. Evidence & Insights, and the Theories of Change underpin the design, and informs decision making

Innovate and disrupt



Act on learnings

Local

Agencies are committed to translating enhancements into core business and adapting local processes and operational policy where the evidence demonstrates benefits.

National

The SASWB will work with central agencies to establish formal mechanisms to proactively present cross cutting themes and evidence to the centre to inform national system change and policy settings.

Executing the strategy: Infrastructure

Governance and management arrangements

The existing governance and management arrangements outlined in Figure 3 below will be strengthened by the establishment of formal iwi and community partnerships, a key element of the 2 year action plan.

Strong connections to central government will be maintained through the Lead Agency, MSD.

Figure 3: Governance and management arrangements (as at June 2020)

Strategic Māori Advisors Group

Strategic Māori advisors from each agency came together in 2019 with the mandate to progress Iwi and Māori participation and leadership across the SASWB. It has taken an approach to explore opportunities across the north, south, east and western parts of Tamaki ki te tonga, South Auckland, starting with Papakura in the south. The Group's work plan will support and enable the Board's achievement of the goals.

Backbone function: The SASWB Implementation Office

Over time, as the collaborative way of working becomes part of the local system's core business, the Implementation Office's function and structure will evolve. However, it is expected that over the next 2 years, it will continue in its current form, hosted by the Counties Manukau District Health Board, and housed in the Multi-Agency Hub - Te Taanga Manawa.

Resources currently funded by the SASWB include:

- 0.5FTE Programme Director
- 1FTE Programme Manager
- 1FTE Evidence and Insights Lead
- 1FTE Evidence and Insights Analyst
- 1FTE Project Manager

Additional resource-in-kind is outlined below:

Role	Agency	FTE
Board participation	All	
Strategic Management Group	All	
Operational Management Groups	Various depending on initiative focus areas	
Implementation Office:		
Project Resource	Ministry of Social Development	0.4 FTE
Start Well Project Lead	Counties Manukau Health Child and Maternal Health	0.2 FTE
Interim Operations manager – Multi Disciplinary Hub (3 months)	Oranga Tamariki	1.0 FTE
SME Māori	Te Puni Kokiri	0.4 FTE
Start Well Social Worker	Oranga Tamariki- Partnering for Outcomes	1.0 FTE
Implementation Office Advisor	NZ Police	0.5 FTE
DHB Support	CMDHB	0.2 FTE

A key piece of work for the Implementation Office over 2020-2021 will be to work with central government to strengthen and present the case nationally for system level change based on the evidence of the SASWB work and the PBI Success Framework.

Appendices Brief descriptions of new work areas

Note: Many of these are in early scoping phase and therefore information is limited

Papakura Marae: A "One-plan, one-system Kaiārahi" in conjunction with the Papakura MDCAT

Facilitating the provision of the right support at the right time, to make safe and keep safe. Objectives:

- To identify the core requirements for a "one plan" way of working at a locality level, (and also what is specific to Papakura)
- To identify the system blockages and enablers of a "one plan" way of working
- To identify the elements of the trusted relationships that required, in order to systematise them rather than relying on individual / personal relationships
- To identify how frontline staff and/or BAU processes can be enabled within existing legislation and policy, to support whānau in a timely manner
- To utilise evidence and insights to recommend operating model improvement opportunities (across the system) that will enable us to make safe and keep safe through appropriate and timely response to whānau, irrespective of where they are in their journey (from crisis through to resilience)
- To apply a "Who's Plan is it anyway" approach.

Papakura Marae: Integrated IHV / MDCAT model building on Family Start and Well Child services JV

A collaborative approach across Family Start and Well Child service provision that is Māori / marae led supported by learnings of Start Well

Objectives:

- To reduce the immediate / future impact of cumulative harm on children.
- To build on learnings from Start Well and MDCAT
- To test the reallocation of existing Family Start resource to higher intensity / lower case load
- To input into a greater understanding of what proportionate universalism means for South Auckland
- To test a flex up / flex down model

Supporting the COVID recovery response by enhancing the CM MDCAT to respond to increased psychosocial distress TBC

Utilising the family harm platform to identify and respond to the increased psychosocial distress as a result of COVID impacts. The SASWB has the infrastructure in place to respond in a collective way that is aligned with the Ministry of Health's "COVID-19: Psychosocial and Mental Wellbeing Plan" which has outlined the need for the system to work together to address the issues.

This will require an enhancement of the CM MDCAT team with psychological / Mental health resource to contribute to the early identification of need and the upskilling of other agencies to understand psychological distress and the support required.

Objective:

- To support the local COVID-19 recovery response using existing platforms and infrastructure
- To evidence the type and volume of need in the community which will inform local design of community-based responses
- To build greater understanding of conditions and support requirements which can then be embedded across agencies.

School psychological response JV

Building on learnings from the Family Harm School Alert initiative, there is recognition that there is a need to:

- Support teachers to identify psychological distress as a result of children being exposed to family harm / violence particularly in the younger age group and prevent longer term impact
- Support children from primary school to secondary school who have been exposed to family harm / violence with an evidence- based intervention.

Objectives:

- To identify existing supports / services already in place that could be repurposed
- To identify and test a tool / programme that will prevent the long-term effects and risk of poor long term outcomes for children exposed to family harm / violence.

Prevention opportunity JV

At risk mums and new-borns

An opportunity to engage earlier with a cohort of mothers and babies identified in at-risk situations, through police call outs for family harm.

Test a flex up / flex down model which integrates learnings from Intensive Home Visiting, MDCAT and SAM unborn alert referrals, utilising a multi-disciplinary needs assessment to determine the most appropriate pathway for support

Objectives:

- To reduce the immediate / future impact of cumulative harm on children.
- To build on cross cutting learnings to date
- To test the reallocation of existing Social Work resource through "Family Success Matters" to higher intensity /lower case load
- To input into a greater understanding of what proportionate universalism means for South Auckland
- To test a flex up / flex down model

Prevention opportunity

Integrated Social Work / Health model for a cohort of children at risk of poor outcomes, identified at FGC intervention.

An opportunity to build on Intensive Home Visiting learnings and align a collaborative response with OT Intensive Intervention / Edge of Care Model

Objectives:

- To input into a greater understanding of what proportionate universalism means for South Auckland
- To test Play30 in a non ECE setting and older age group
- To test a flex up / flex down model

Change Champions – embedding learnings and performance improvement opportunities back into agencies

Identifying senior level "change champions" (part funded by SASWB) within agencies who have dedicated time and resource to champion nmulti-agency, multi-disciplinary working by:

- Working closely with the SASWB and other partner agencies, focussed on leading, enabling and influencing individual agency participation in collaborative activities
- Identifying and championing improvement opportunities within their respective organisation, where collective working identifies opportunities to optimise their operating models and therefore outcomes for whānau
- Contributing to future thinking through the SASWB Senior Management Group

They would be responsiblefor:

- Embedding learnings into agencies and leveraging these for the benefit of their own agency
- Connecting appropriate agency services with multi-agency initiatives
- Identifying and accessing the right skill sets, expertise and experience to support multi-agency activity
- Participating in SMG

Multi-agency "intensive case management" function -- drawing on / streamlining existing agency ICM resources

A proposal to test a collaborative Intensive Case Management model that brings together existing Intensive Case Management resources from agencies into one place acknowledging that the stressors are the same and require a collaborative approach to address these. No one agency can deliver all.

A possible opportunity is to build on the agency co-location and the one plan Kaiārahi that is already underway at Papakura Marae.

Objectives:

- To test the ability to achieve better integration and efficiencies from one collaborative service vs multiple agencies working with one whānau to address the same underlying stressors
- To test an end to end approach where one "thing" walks alongside whānau through multiple agencies/ services and through crisis and resilience building.

Workforce development – embedding a culture of collaborative way of working and "can do" attitude at all levels of organisations

Key pieces of work will be:

- Establish a cross agency / system training schedule – drawing on existing training programmes / learning opportunities which upskill staff on the shared vision, purpose and ways of working. Share case studies wider and utilise existing staff working in collaborative models to present and share learnings.
- Building collaborative working / multi-agency roles into a desirable career pathway – 'legitimising' / creating transdisciplinary roles

Information Paper
Counties Manukau District Health Board
Occupational Health & Safety Performance Report

Recommendation

It is recommended that the Board:

Receive the Health and Safety report for the period 1 September 2020 - 31 October 2020.

Note this report was endorsed by the Executive Leadership Team on 24 November to go forward to the Board.

Prepared and submitted by: Kathy Nancarrow, Health and Safety Manager, and Elizabeth Jeffs, Director Human Resource.

Glossary for Monthly Performance Scorecard and Report

Lost time incidents	Any injury claim resulting in lost time.
Lost time injury Frequency Rate	Number of lost time Injuries per million hours worked. **LTIFR (Lost Time Injury Frequency Rate)** = (Number of Lost Time Injuries / Hours Worked) x 1,000,000.
Injury Severity Rate	Mathematical calculation that describes the number of lost hours experienced as compared to the number of hours worked. **LTISR (Lost Time Injury Severity Rate)** = (Number of Lost Hours / Hours Worked) x 1,000,000.
Notifiable Injury/illness	(a) Amputation of body part, serious head injury, serious eye injury, serious burn, separation of skin from underlying tissue, a spinal injury, loss of bodily function, serious lacerations. (b) any admission to hospital for immediate treatment (c) any injury /illness that requires medical treatment within 48 hours of exposure to a substance (d) any serious infection (including occupational zoonosis) to which carrying out of work is a significant factor, including any infection attributable to carrying out work with micro-organisms, that involves providing treatment or care to a person, that involves contact with human blood or bodily substances, involves contact with animals, that involves handling or contact with fish or marine mammals. (e) any other injury/illness declared by regulations to be notifiable.
Notifiable Incident	An unplanned or uncontrolled incident in relation to a workplace that exposes a worker or any other person to a serious risk to that person's health or safety arising from an immediate or imminent exposure to an escape, spillage or leakage of a substance; an implosion explosion or fire; an escape of gas or steam; an escape of a pressurised substance; an electric shock; a fall or release from height of any plant or substance; collapse or partial collapse of a structure; interruption of the main system of ventilation in an underground excavation or tunnel; collision between two vessels or capsize; or any other incident declared by regulations to be a notifiable incident.
Notifiable Event	Death of a person, notifiable injury or illness or a notifiable incident.
Pre-Employment	Health screening for new employees.
Worker	An individual who carries out work in any capacity for the PCBU e.g. employee, contractor or sub-contractor, employee of the sub-contractor, employee of labour hire company, outworker, apprentice or trainee, person gaining work experience, volunteer.
Reasonably Practicable	Means that which is or was at a particular time reasonably able to be done in relation to ensuring health and safety, taking into account and weighing up all relevant matters.eg the likelihood of the hazard/risk occurring and the degree of harm resulting, what the person knows about hazard/risk and how to eliminate/ minimise the risk and

	the cost associated with elimination of the hazard/risk.

Glossary

ACC	Accident Compensation Commission
AEP	Accredited Employer Programme
ARF	Audit, Risk and Finance
ASRU	Auckland Spinal Rehabilitation Unit
BBFE	Blood and/or Body Fluid Exposure
BAU	Business as Usual
CCS	Central Clinical Services
DHB	District Health Board
EAP	Employee Assistance Programme (Counselling)
ELT	Executive Leadership Team
F&E	Facilities and Engineering
HR	Human Resources
HSNO	Hazardous Substance New Organisms Act
HSR	Health and Safety Representative
HSR NZQA	Health and Safety Representative New Zealand Qualifications Authority
HSWA	Health and Safety at Work Act 2015
IMT	Incident Management Team
IRS	Incident Reporting System
JCC	Joint Consultative Committee
LTI	Lost Time Injury
MH&A	Mental Health and Addictions
MMC	Middlemore Central
NZDF	New Zealand Defence Force
OHN	Occupational Health Nurse
OHP	Occupational Health Physician
OHSS	Occupational Health and Safety Service
PCBU	Person Conducting a Business or Undertaking
PHCS	Primary Health & Community Services
PEHS	Pre-Employment Health Screening
SPHM	Safe Patient Handling and Moving
SPEC	Safe Practice and Effective Communication
TAS	Technical Advisory Services Limited
WellNZ	Injury Management Third Party Administrator

Purpose

The purpose of the Health and Safety report is to provide monthly reporting of health, safety and wellbeing performance including compliance, indicators, issues, risks and project activity to the Counties Manukau District Health Board. This report covers Health and Safety performance statistics for the months of September and October 2020.

November Activity

The OHSS team have spent time in November planning for the busy Christmas period and resetting projects that were underway throughout the year including:

- The respirator mask fit testing program has continued with on boarding and training of dedicated CM Health staff to run the program as an internal project.
- OHSS have provided respirator mask fit testing kits to nurse educators based in the MIQFs who are now testing across the facilities, with results being collated by the CM Health program coordinator.
- The OH team has been collaborating on a number of issues with ADHB OH team i.e. how they can

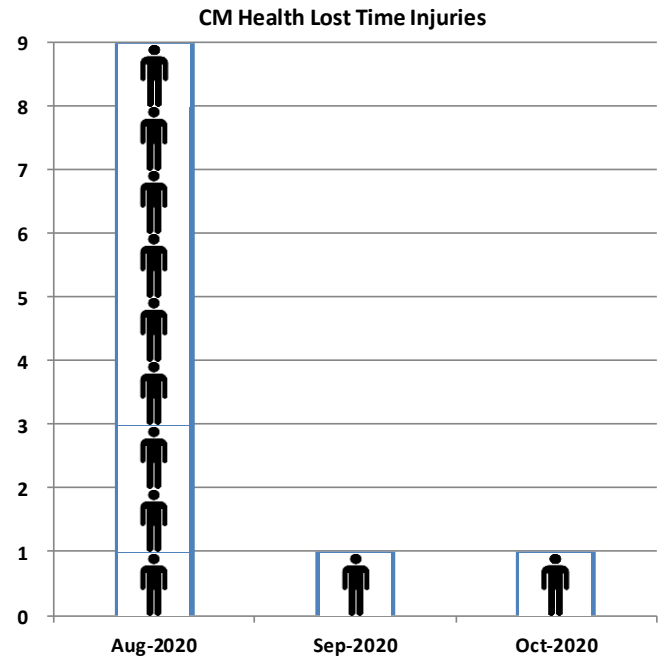
utilise OH software as CM Health does, and how DHBs can improve OH pre-employment health screening process / experience.

- The dermatitis project is progressing with increasing use of the self-referral form; there are plans to increase awareness across the business in early 2021.
- The regional HSR training plan in conjunction with ADHB and WDHB is nearing completion, with a preferred provider being agreed, subject to agreement of T&Cs.
- OHS has developed of a health & safety management system self-assessment tool, to be presented to ELT. Subject to approval of the tool, a provisional pilot launch in the business is planned for early 2021.
- Planning continues to build the evidence for the up and coming ACC AEP audit in February 2021.
- The Get Home Safe app continues to be implemented across the organisation.
- Work continues on the development of a more interactive H&S risk register / assessment system.

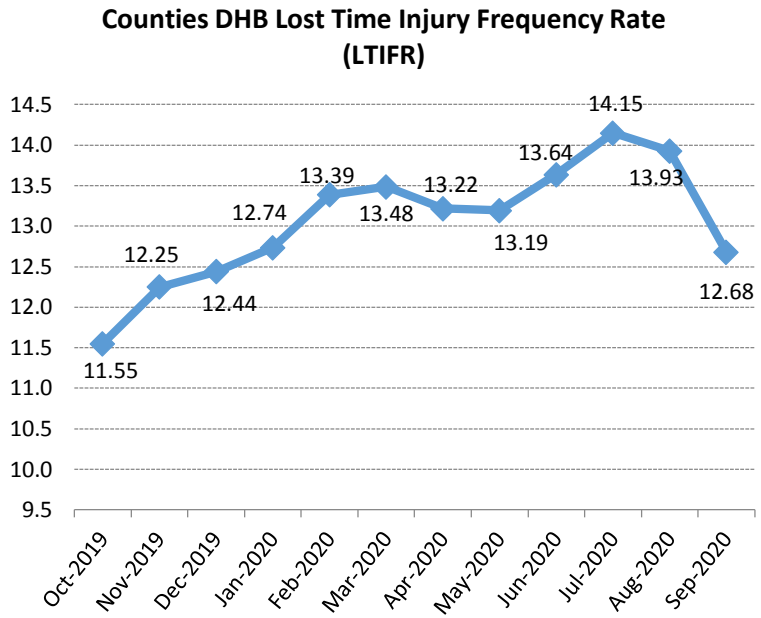
20 DHB managers have come together in November for a third face-to-face Hui, facilitated by TAS with plans for collaboration on projects and sharing of occupational health and safety procedures. This venture is valuable for CM Health as it will enable us to share in critical risk project activity and ensure a national governance approach for keeping our people safe and well.

CM Health H&S Dashboard – September/October 2020

LTI's



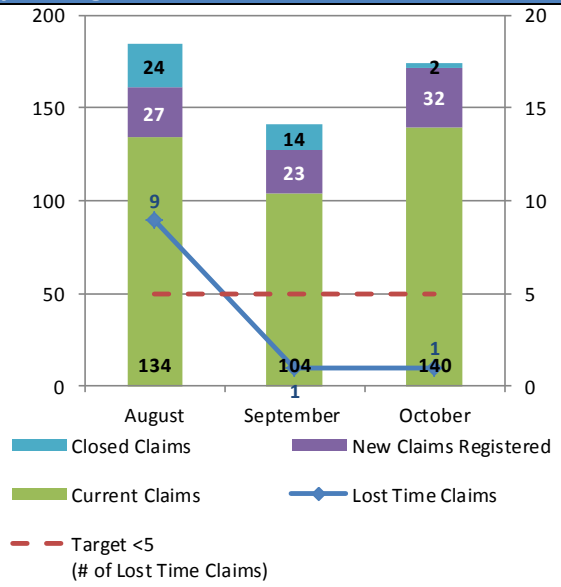
LTIFR – 12 month rolling average



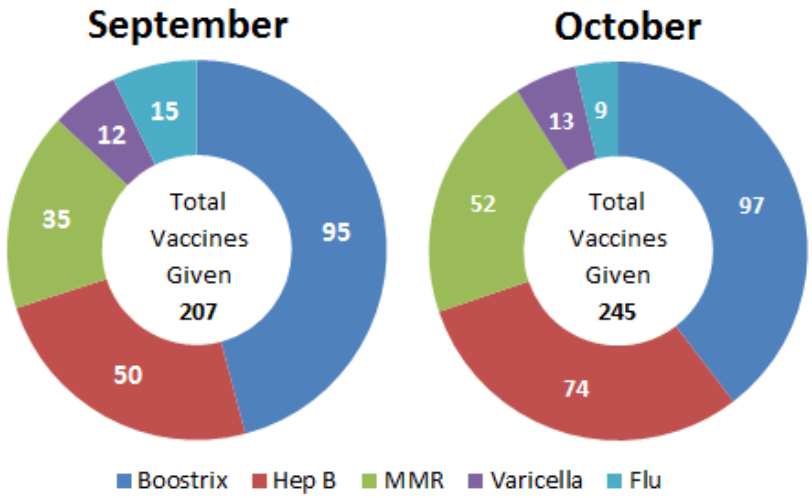
Critical Risk Incidents

September	Risk	October
53	Violence & Aggression	59
30	Moving & Handling	32
31	BBFE	39
20	Slips, Trips & Falls	5
40	Stress	43

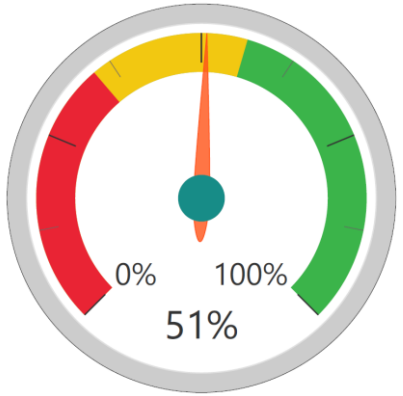
Injury Management Claims



Vaccinations



CM Health Safe365 Aggregated Score



NZ Market Average = 52%

Guide to Safe365 Health & Safety Index
0%-20%: Very low H&S capability. Take urgent actions to improve.
21%-40%: Some H&S capability present, significant improvements needs to achieve basic compliance
41%-60%: A number of areas of good H&S capability. Some work-ons required to achieve basic compliance
61%-80%: General level of compliant H&S capability achieved
81%-100%: Comprehensive H&S capability achieved, areas of excellence being exhibited

Executive Summary

Most OHSS staff returned to the office during September and October with some staff working off site where possible. Clinics were running face-to- face as normal with on the phone consultations for remote areas and Managed Isolation and Quarantine Facilities (MIQFs).

Pre-employment testing numbers have increased across CM Health facilities however this increase was predominantly due to the increased recruitment of staff into MIQFs. Vaccinations clinics are at normal rates however OHSS are continuing to provide more vaccinations due to experiencing an increase in new employees with no immunity to diseases such as measles.

On-going meetings and activity continued with MBIE and NZDF in regards to the management of H&S at MIQFs including OHSS facilitation of inductions and HSR involvement.

During September and October the H&S team were focused on gathering the evidence required for the ACC AEP audit scheduled for February 2021. The self-assessment review was completed and HSR's invited to a meeting where results were communicated. Following this review the annual OHSS review has been completed which has provided discussion on OHSS targets, KPIs and priorities for the 2021 – 2022 period.

Respiratory mask fit testing plans were well underway in October with the OHSS team carrying out recruitment for the new roles and exploring the processes for the long term sustainable fit testing program, which will allow us to progress from the current interim mask fit test stage.

The OHSS team have carried out a significant risk review on the Corporate Risks around keeping our workers safe and well (risk number 2.18). A paper has been prepared and presented to the ELT providing recommendations and action plans.

Occupational Health

Onsite clinics for OHSS physicians were 157 in September and 111 in October from 105 in August. OHSS nurse appointments were 164 in September and 153 in October. Recalls for workers to attend follow up appointments and vaccinations are on-track and back to normal due to some delays during COVID-19 restrictions.

Contact Trace (CT)

There were two contact traces conducted during September:

- one Probable COVID-19 contact trace involving 43 staff from Emergency Care, Ward 33, Radiology and Orderly Services. 10 staff members were established as CLOSE contacts that required stand down from work. Following further investigation from Infection Control the case was declassified and the staff members were able to return to their normal duties.
- one Tuberculosis contact trace involved 26 staff from Emergency Care, Ward 7, ICU and Ward 32. All were deemed Casual Contacts due to appropriate PPE use.

Two contact traces occurred during October:

- one for chicken pox in Women's Health – all staff were immune requiring no stand down.
- one contact trace for meningococcal disease which involved staff from Emergency Care and Kidz First Medical. All staff members were deemed to be casual contact due to their appropriate PPE use.

The OHSS team is continuing to adapt its CT process to implement the National Contact Tracing System (NCTS) into the occupational health work flow.

Hands (Dermatitis) Project – Update

Occupational hand dermatitis is a common issue for workers in healthcare.

Workers who wished to have Occupational Health input into the management of their occupational hand dermatitis were asked to complete an incident form using the CMH online incident reporting tool. The online self-referral form is now available on the Occupational Health intranet page. This was developed as a proactive OHSS project to assist in streamlining the reporting process. The referral form is submitted directly to the OH nurse for review and management. Evidence since this project was implemented suggests some workers have completed the form.

OHSS emergency scenario testing

The OHSS team members are a group of qualified professionals who carry out a range of clinical activities to support staff wellbeing and care and as such could face an emergency situation at any time as would any other clinical areas at CM Health.

All the Occupational Health and Safety Nurses who administer these vaccinations are Independent Vaccinators and as such trained to appropriately respond in the event of an adverse event following vaccination, the most serious of which is anaphylaxis. Any medication can cause a severe allergic reaction. Such reactions from a vaccine are very rare, estimated at about 1 in a million doses, and could happen within a few minutes to a few hours after a vaccination. The OH Team must be prepared for this possibility.

On Wednesday the 21st of October, the Occupational Health (OH) Lead Clinic Nurse ran three short emergency scenarios for the OH Nurses and OH Physician. The three scenarios dealt with possible situations that could arise following a vaccination event.

A colleague was instructed to display symptoms of three possible adverse events; Syncope (vasovagal reaction), or fainting, which can be triggered by various stimuli, including medical procedures such as vaccination, and two presentations of anaphylaxis. The nurses were expected to play act their response to these situations and describe their actions. Due to Occupational Health and Safety's physical location, in the event of a medical emergency an ambulance must be called to transport the patient to the Emergency Department. This requires the Occupational Health Nurse to call 1-111, as well as dialing 777 for the PAR Team.

Following the scenarios, discussion was held to review actions and learnings. The findings were;

- The OHP and OHN's responded very quickly to the initial call for assistance.
- Although the 3 nurses responded quickly, it was noted that nobody took the lead in the scenario.
- It was noted that the OH Clinic is not equipped with a cardiac monitor and any drugs other than adrenaline and oxygen. There is no equipment for inserting a luer for additional drugs or intravenous (IV) fluids.
- It is not known what the PAR team would bring with them when they respond to an emergency call, or if the nearest Emergency Trolley would need to be retrieved – which is situated in Ward 23 (5-10 minutes away). The PAR team has been contacted by the OH Lead Clinic Nurse to establish what equipment they bring with them if called to Occupational Health in an emergency situation.
- The OH Nurses expressed a desire to have a portable BP machine with pulse oximeter, as is available in the wards. This would enable the continuous monitoring of the collapsed patient in the event of a medical emergency. It is also noted that the clinic room is currently also used as a storage room – due to lack of available space in Occupational Health. This compromises access to the clinic bed in the event of an emergency.
- All the staff who participated in the scenarios felt that it was a very useful experience.

Actions for the OH Nurses

- Familiarisation with the clinic room equipment i.e. the operation of the clinic bed, and emergency bag contents

- Make physical changes to the layout in the Occ Health clinic to allow easy access around the bed
- Establishing a lead in the event of an emergency response

It is planned to repeat this exercise on a regular basis.

Occupational Physicians

The Occupational Health physicians continue to be involved in regional and national work groups including establishing procedures for respiratory mask fit testing. Work continues with the on-going review and support of our vulnerable workforce along with advisory support for the Occ Health nurses.

Occupational Health and Safety

The October communication saw the launch of OHSS alerts. Their purpose is to communicate important and critical learning's or address a gap in knowledge identified, usually from a reported incident investigation or a risk that has been raised. They are targeted towards all areas of the business. HSRs are required to discuss them as part of their allocated time in team meetings and copies are placed on the Health & Safety notice boards. Refer to Figure 3 and 4 for the examples presented to HSRs in October 2020.

To ensure Health & Safety notice boards were updated with the new policy statements and emergency procedure flip chart, and as part of our worker engagement and participation, a planogram was created and shared with the standard October H&S communication. To further imbed the requirement to update the information and to celebrate the creativity already invested in the noticeboards boards, a competition is being run with a prize for the most creative entry. The winners will be announced in December

Respiratory Face Masks

Recruitment processes are completed and the new workers are carrying out their on-boarding processes, with their workplace location being the OHSS office in Esme Green. Procedures are being developed in conjunction with Occ Health physicians and the National advisors groups. In the interim, the use of the external contractor has continued, to meet organisation demand.

Violence and Aggression Project

The Management of Violence & Aggression Steering Group, Emergency Care and Mental Health & Addictions have provided feedback on the OHSS gap analysis piece following a review of the recently published WorkSafe Violence in the Health and Disability Sector Guide. Response are being collated with the intention of evaluating how this can be a cohesive part of CM Health's present and future plans to minimise the risks of violence and aggression to our staff and in our community.

One recommendation from the gap analysis will be to have a permanently appointed and supported violence and aggression focus group that meet frequently to work through the actions and advise the leaders of CM Health on proactive initiatives as well as analyse incident trends on a regular basis.

The 20 DHB H&S managers are also working on initiatives to reduce the risk of harm from violence and aggression, more information will be available in the near future on these initiatives.

Lone Workers Project

The pilot program to test the lone working device has been launched with Mental Health & Addiction Community Teams. This pilot will enable the OHSS and Security teams to assist in managing the risk of lone work.

Managed Isolation and Quarantine Facilities – COVID-19 work

CM Health OH&S team continue to contribute to the MBIE (lead PCBU) risk assessment and agreeing how the overlapping duties with NZDF and MBIE will be undertaken in the Northern region.

Three Clinical Educators trained by 3M, are undertaking mask fit testing working to CM Health's process, and providing education on usage, risk assessment is being used to identify the requirement for respirator mask usage.

OHSS continue to facilitate the H&S inductions are required for new DHB staff at MIQFs.

CM Health Occupational Health team continue to support the DHB staff to be employed in the MIQF and optimised current DHB recruitment guidelines and processes to support the recruitment process.

Injury Management

In October, 32 new workplace injury management claims were registered which is an increase from 27 in August, compared with September where there were 23 new claims registered. There was 1 lost time claim reported in both September and October. A total of 140 claims were being managed by the Counties Manukau and WellNZ Case Managers in October with 104 being managed during September.

ACC Accredited Employers Program (AEP)

Work continues gathering evidence in preparation for the ACC Accredited Employers Program audit on 2nd and 3rd February 2021. OHSS expect to be informed in late December details of the injury management claims ACC will review for the AEP audit.

Health and Safety Representatives were invited to attend the annual self-assessment meeting in September 2020. A summary of the findings was presented at the Executive H&S Committee.

Incident Reporting

During September and October there were (177) and (173) incidents reported to OHSS, this is a slight decline on August reporting (199). Contractor Incidents were (7) and (8) during these two months.

Our highest numbers of reported incidents in September and October were Aggression & Violence 53 and 59 when compared with 58 in August. Reported stress incidents numbers were 40 and 43 which is an increase from 31 in August. Moving and Handling incidents were consistent with 29 in August (30 and 32).

There was an increase in BBFE incidents in October (39) from 31 in September and 32 in August.

11 incidents were reported from MIQF including;

- 6 - referring to staffing issues over a number of days (reported by the same person)
- 2 - inappropriate behaviour
- 3 - injuries referred to Injury Management at CM Health.

The OHSS H&S Advisors continue to triage incidents reported as impacting workers and offer assistance where required.

Event Requiring Notification to WorkSafe

There were 2 events reported to WorkSafe in September 2020:

- 15/09/2020 – a visitor was injured by a length of wood falling from ceiling hatch as they entered Scott building. A detailed FEAMs investigation was conducted and remedial work undertaken across the hospital including actions involving contracting partners.

- 20/09/2020 – three security officers were threatened by a potential armed offender in Emergency Care. Police armed response occurred and two individuals were arrested, ambulances were diverted away from Middlemore during this time.

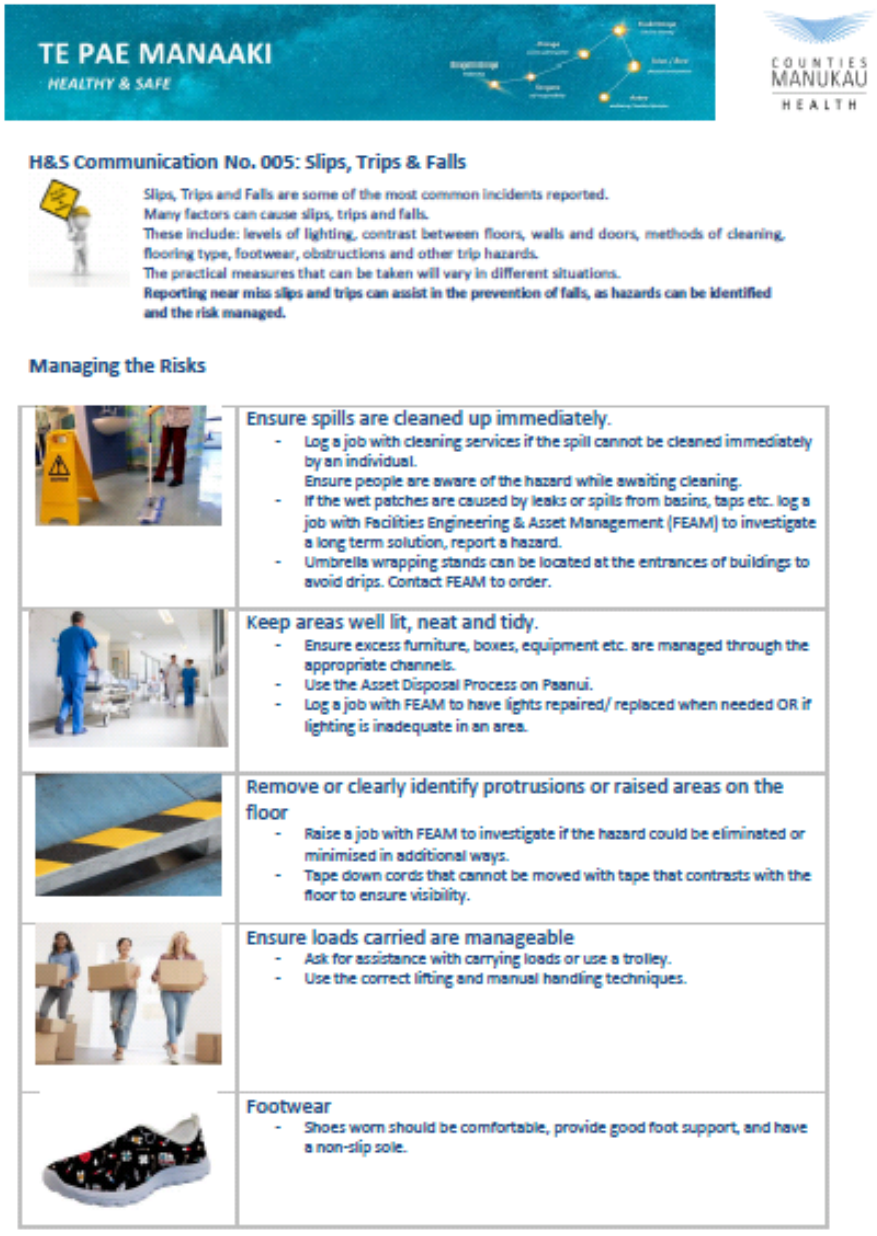
WorkSafe have not investigated either event further.

OHSS Communication Topics

The H&S communications for September and October were;

- Slips, trips and falls
- Noticeboard planogram for H&S posters required at work areas
- Post incident Safety Alerts for managing broken/faulty facilities and sharps left in scrubs sent to laundry

Figure 1: OHSS Communication – 005: Slips, Trips, and Falls



Managers and H&S Representatives Guide to Communicating this message:

***Oranga* – Our Society (Safety at CM Health): What do managers and H&S Reps need to know;**

- Everyone has a responsibility to report incidents, near misses and risks that are identified either through the online tool or a nominated person who will then enter it on the online tool.
  The link to the online reporting tool can be found on Paanui.

***Rangatiratanga* - Leadership: Manager's responsibilities**

- Managers have a key responsibility to help develop and maintain an environment that encourages reporting through the growth of a just culture.
- Managers need to ensure their entire workforce is able to report risks, hazards incidents and injuries, either through training them on how to use the online tool or giving them access to someone who is able to enter the report on their behalf.
- Managers need to ensure issues identified on the bi-monthly checklist are addressed. If necessary, someone can be nominated to assist with the management of the process.
- Keep records of the discussion of this communication and the actions taken to address risks and hazards for auditing purposes.

***Tuakiritanga* - Positive Health and Safety Culture: H&S Representative's responsibilities in regards to this topic;**

- Assist managers with bi-monthly checklists and managing issues identified.
- Help staff learn how to log jobs with FEAM.
- Place this communication topic on the staff noticeboard and assist with educating staff on how to report.
- Escalate to the OHSS Team any matters that need to be raised.

Tools needed to communicate this topic;

- Refer to the Maintenance & Repair page on Paanui for process to have repairs done to building.
- Refer to the Asset Disposal Process page on Paanui for process to get rid of excess furniture and equipment.

Figure 2: OHSS Communication –H&S Noticeboard Planogram

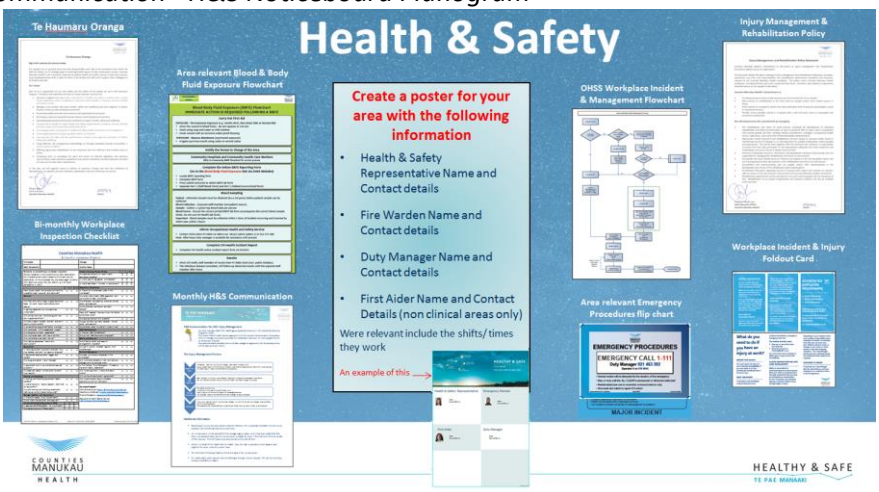
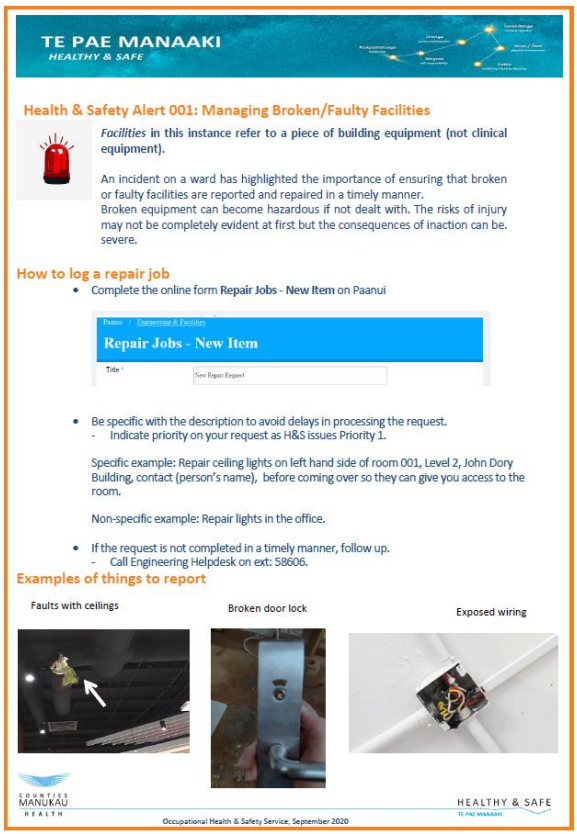
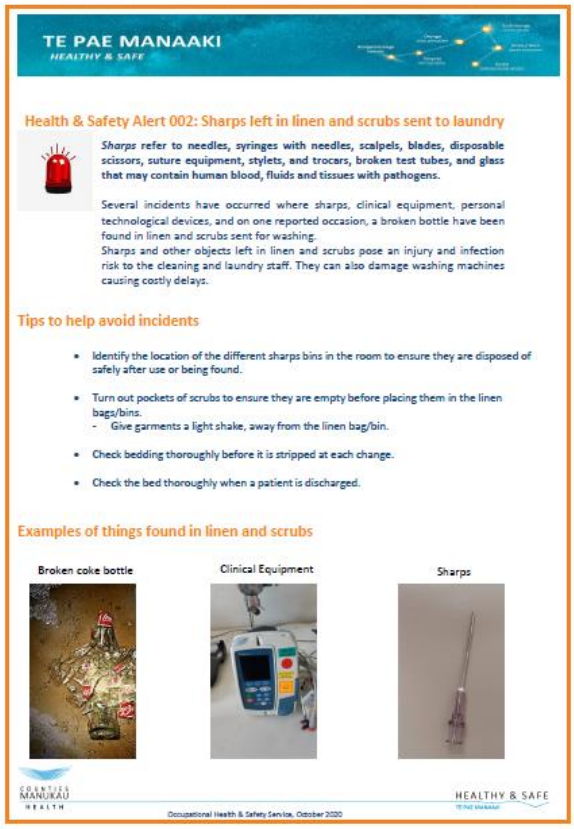


Figure 3: OHSS Communication –001: Safety Alert, Managing broken/faulty facilities
Figure 4: OHSS Communication –002: Safety Alert, sharps left in scrubs sent to laundry





Worker Participation

The HSR training tender process continues with the other Northern Region DHBs. This will ensure a robust training program that meets the ASNZ Standards and HSWA is in place for our HSRs and include the offering of additional training programs for Risk Management as well as Auditing and Investigation. Two additional HSR training sessions are planned for December 2020 at CM Health to ensure regular offerings for new HSRs in the meantime.

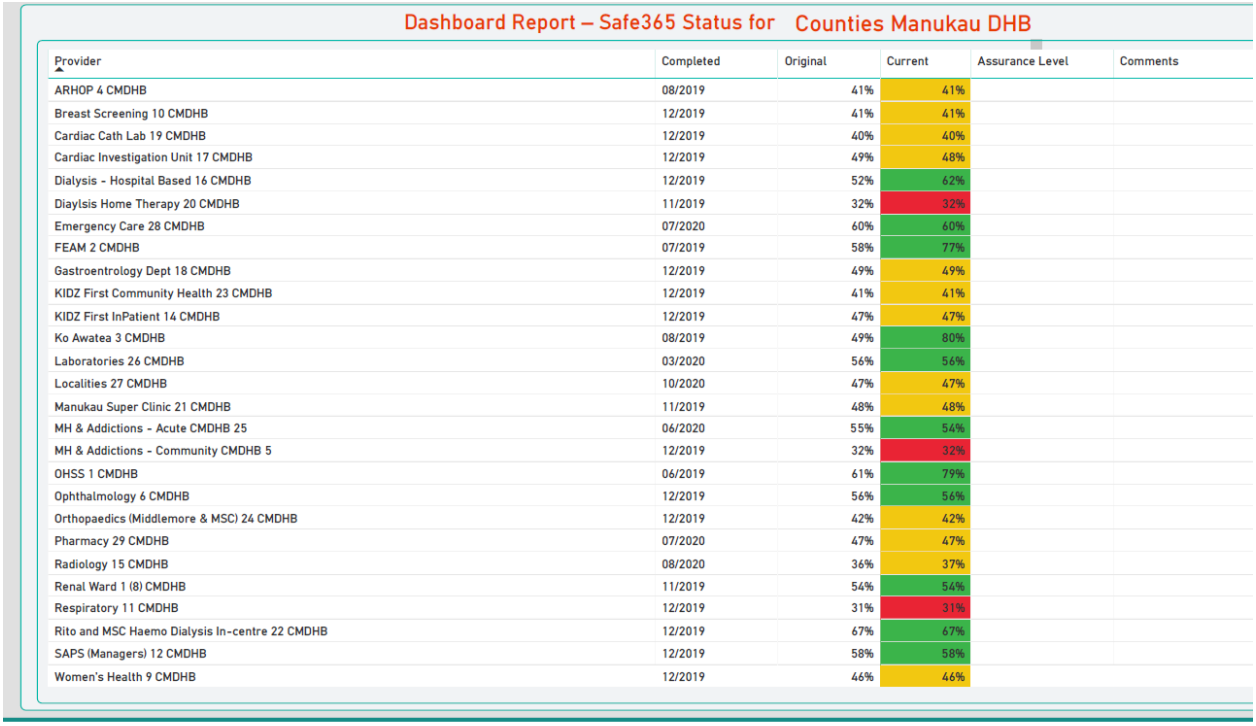
To recognise the contribution HSRs make, a Health & Safety Star programme was launched. Recipients are nominated by their teams or members of OHSS for their work to promote Health & Safety through engagement activities carried out, support offered and providing innovate ideas.

Safe365

The current score for CM Health is 51%. OHSS has facilitated initial assessments for HR (specifically OHSS) and Locality Services. The dashboard score achieved for OHSS/HR was 79%, this was encouraging with Management Reporting and Worker Engagement showing strong capability. An area for improvement is Verification & Audit Activities.

With the Initial assessments almost completed the next step will be a review of Safe365 implementation. OHSS are currently working with Medicine reviewing the coverage and implementation of Safe365 within their Division. Learnings from this will be shared with other divisions. Safe365 developers are aware that navigating some areas of the software is not straight forward and they are working on back end development to make improvements in this area. These improvements are due to be available to CM Health in the New Year.

Date	Division/Service	Type of Session
07/10/2020	OHSS/HR	Initial Assessment
19/10/2020	Localities	Initial Assessment



Dashboard Report – Safe365 Status for Counties Manukau DHB

Provider	Completed	Original	Current	Assurance Level	Comments
ARHOP 4 CMDHB	08/2019	41%	41%		
Breast Screening 10 CMDHB	12/2019	41%	41%		
Cardiac Cath Lab 19 CMDHB	12/2019	40%	40%		
Cardiac Investigation Unit 17 CMDHB	12/2019	49%	48%		
Dialysis - Hospital Based 16 CMDHB	12/2019	52%	62%		
Diaylsis Home Therapy 20 CMDHB	11/2019	32%	32%		
Emergency Care 28 CMDHB	07/2020	60%	60%		
FEAM 2 CMDHB	07/2019	58%	77%		
Gastroentrology Dept 18 CMDHB	12/2019	49%	49%		
KIDZ First Community Health 23 CMDHB	12/2019	41%	41%		
KIDZ First InPatient 14 CMDHB	12/2019	47%	47%		
Ko Awatea 3 CMDHB	08/2019	49%	80%		
Laboratories 26 CMDHB	03/2020	56%	56%		
Localities 27 CMDHB	10/2020	47%	47%		
Manukau Super Clinic 21 CMDHB	11/2019	48%	48%		
MH & Addictions - Acute CMDHB 25	06/2020	55%	54%		
MH & Addictions - Community CMDHB 5	12/2019	32%	32%		
OHSS 1 CMDHB	06/2019	61%	79%		
Ophthalmology 6 CMDHB	12/2019	56%	56%		
Orthopaedics (Middlemore & MSC) 24 CMDHB	12/2019	42%	42%		
Pharmacy 29 CMDHB	07/2020	47%	47%		
Radiology 15 CMDHB	08/2020	36%	37%		
Renal Ward 1 (8) CMDHB	11/2019	54%	54%		
Respiratory 11 CMDHB	12/2019	31%	31%		
Rito and MSC Haemo Dialysis In-centre 22 CMDHB	12/2019	67%	67%		
SAPS (Managers) 12 CMDHB	12/2019	58%	58%		
Women's Health 9 CMDHB	12/2019	46%	46%		

Guide to Safe365 Health & Safety Index
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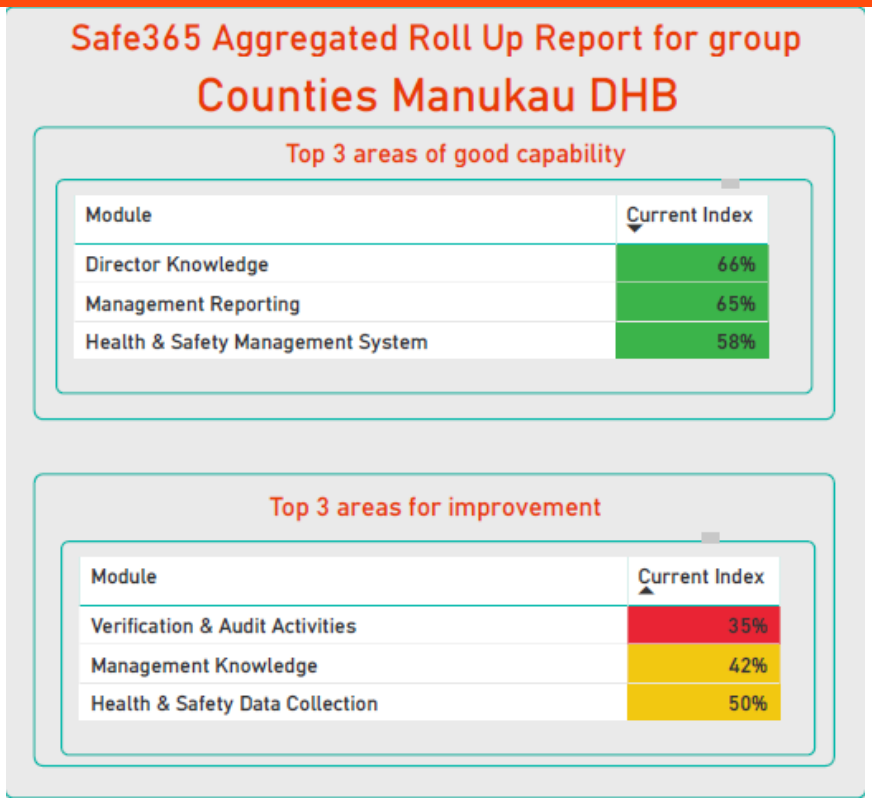
21%-40%: Some health & safety capability present, significant improvements needs to achieve basic compliance
41%-60%: A number of areas of good health & safety capability. Some work ons required to achieve basic compliance.
61%-80%: General level of compliant health and safety capability achieved.
81%-100%: Comprehensive health and safety capability achieved, areas of excellence being exhibited.

All Provider Index
51%



Safe365 Aggregated Roll Up Report for group
Counties Manukau DHB

Top 3 areas of good capability

Module	Current Index
Director Knowledge	66%
Management Reporting	65%
Health & Safety Management System	58%

Top 3 areas for improvement

Module	Current Index
Verification & Audit Activities	35%
Management Knowledge	42%
Health & Safety Data Collection	50%

Health and Safety Performance Scorecard

Lagging Indicators		August 2020	September 2020	October 2020	Target
Reported Incidents	Counties Manukau Staff	199	177	173	~
	healthSource (hS staff working at CM Health sites)	0	5	6	~
	Contractors	1	2	2	~
	Visitors	0	0	0	~
Near Miss reported Incidents		3	1	0	~
Injury Claims	New Claims Registered	27	23	32	~
	Current Claims	134	104	140	~
	Declined Claims per month	14	11	0	~
	Closed Claims per month	24	14	2	~
	Lost Time Claims	9	1	1	<5
	Days lost per month (due to Lost Time Claims)	17	12	10	~
	Lost Time Frequency Rate (LTIFR)	10.23	12.68	Unavailable	<10
	Lost Time Severity Rate (LTISR)	357.47	90.22	Unavailable	<630
	Claims costs (monthly)	$76354.97	$76624.05	$69064.02	~
Critical risk incidents	BBFE	32	31	39	~
	Aggression & Violence	58	53	59	~
	Moving & Handling	29	30	32	~
	Slips, Trips, Falls	13	20	5	~
	Stress	31	40	43	~

Leading Indicators		August 2020	September 2020	October 2020	Target
Pre-employment	Health screening	93.8%	95%	85.9%	100%
Clinic appointments	Dr & Nurse clinics	200	321	264	~
Vaccinations	Flu, dTap, VZV, HepB and MMR	105	207	245	~
Safe365 activity and implementation	30 accounts allocated*	2	0	2	100%
Training sessions attended (OHSS team)	Occ Health Physicians CPR training	0		1	~
OHSS Communications	**August:** Injury Management (003) **September:** Slips, Trips, and Falls (005) **October**: H&S Alert - Managing Broken/Faulty Facilities (001), H&S Alert – Sharps left in linen and scrubs sent to laundry (002)	1	1	2	~
Risk Assessments completed	Corporate risk 2.18 deep dive	0	1	0	~
Workplace Inspections	The next inspection is due 11th December 2020	0	0	0	Bi-monthly
HSW internal audits, self-assessments underway	ACC self-assessments for critical elements in AEP	0	1	0	~

* The Occupational Health and Safety team are currently reviewing licences for the Safe365 program and plan to realign the way some service areas were initially set up to ensure better co-ordination. An ELT paper is being prepared for discussion in October which will provide clarity on service areas that are yet to be set up.

Key Indicators Commentary	
LTIFR	12 month rolling average figure is above the target (10) at 12.68 in September 2020 (1 lost time incident claim). The September 2020 figure (12.68) decreased from the August 2020 figure (13.93).
LTISR	October figure (90.22) has decreased from the September figure (357.47).
Claims costs	Monthly claims costs have increased from $76624.05 in September to $69064.02 in October.
Pre-employment Health Screening	248 of the 261 PEHS received for new starters in September were cleared prior to them commencing employment, which equates to 95%. 231 of the 269 PEHS received for new starters in October were cleared prior to them commencing employment, which equates to 85.9%.
Dr & Nurse clinics	Decrease in OCC Health clinic appointments in October (264) when compared to September (321) figure.
Vaccinations	Increase of vaccinations administered in October (245) when compared to September (207).

LTIFR

The LTIFR rolling average figure decreased in September to 12.68 from 13.93 in August 2020 (with 1 lost time claim in September and 9 in August). Figure for October is not yet available. Note these figures change monthly due to late submissions to payroll, and late submissions of claims which can result in a change in the LTRFR from what was reported previously.

Lost Time Claims August

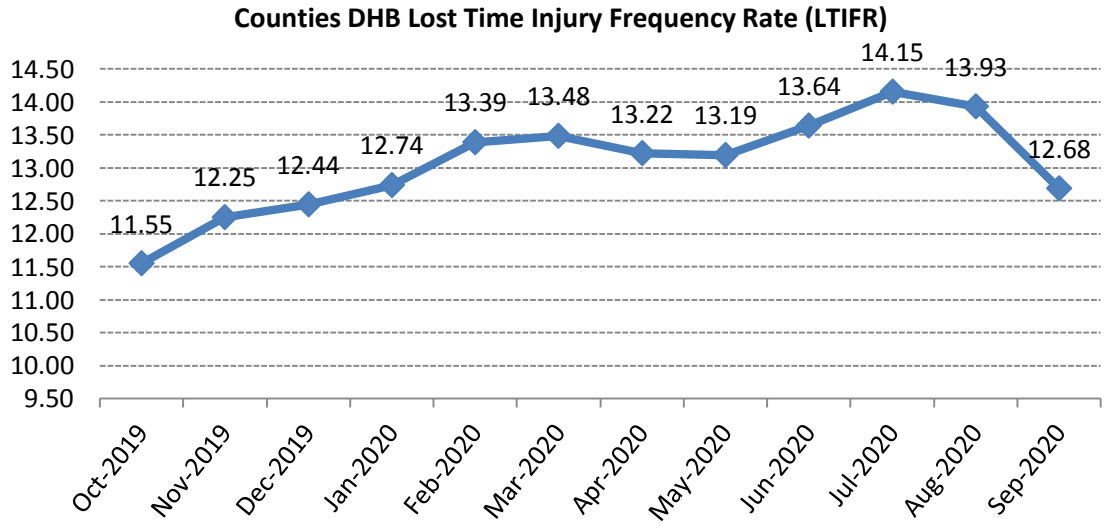
- 3x Lumbar sprain
- 1x Cellulitis of face
- 1x Sprain and strain of other and unspecified parts of knee
- 1x Ankle sprain
- 1x Head injury
- 1x Back sprain NOS
- 1x Thoracic sprain

Lost Time Claims September

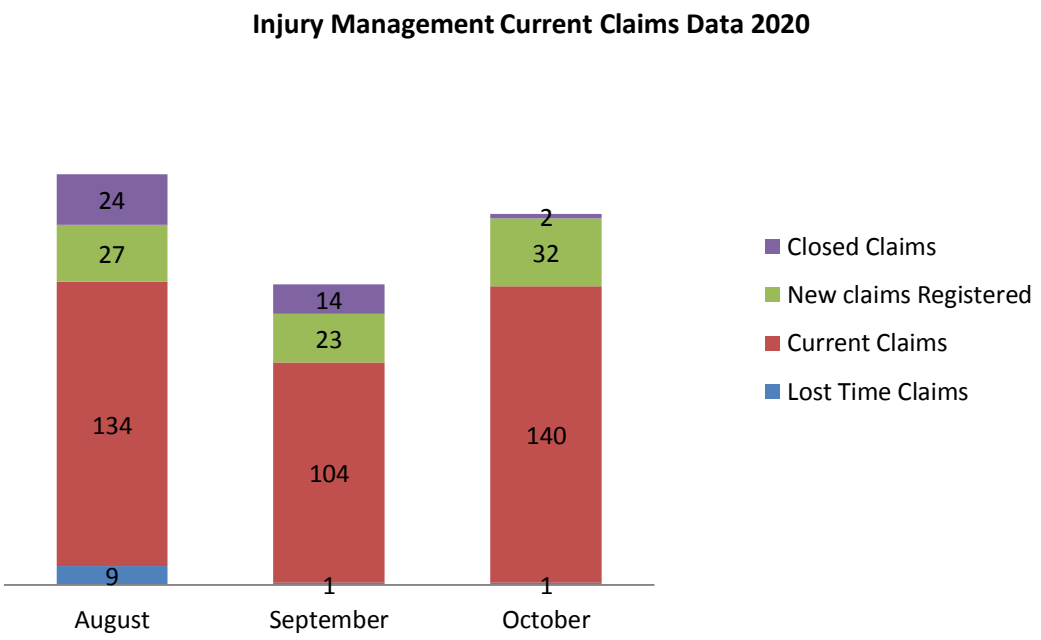
- 1x Lumbar sprain

Lost Time Claims October:

- 1x Contusion - Finger



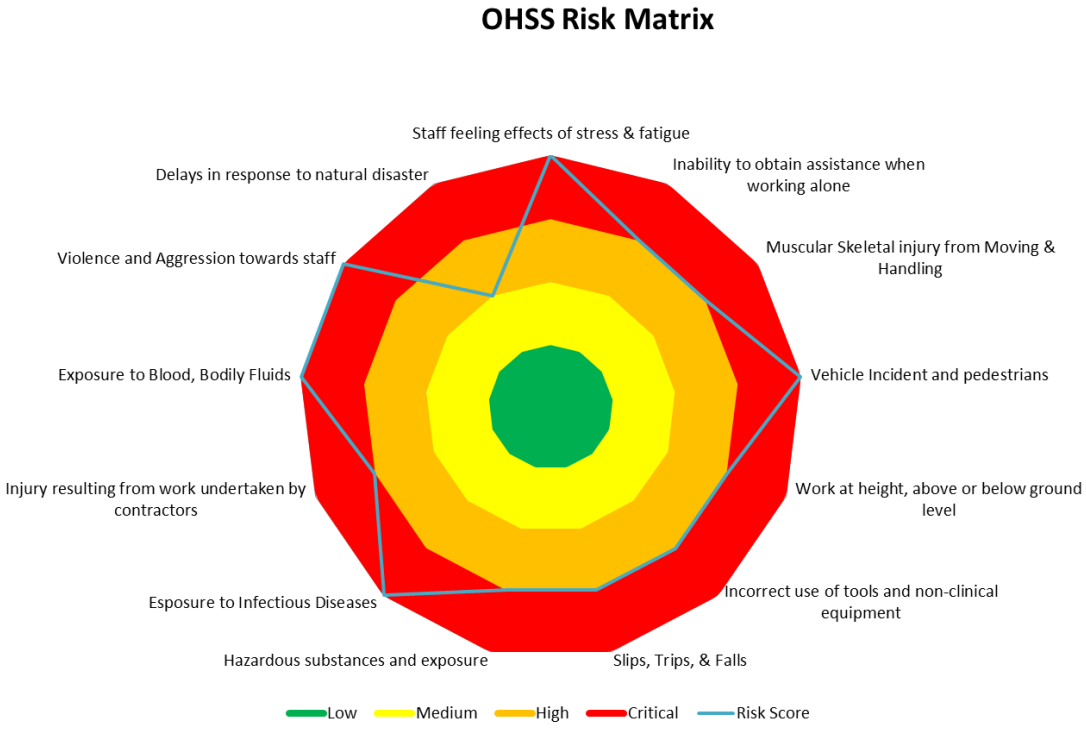
Claims Data (by month)



- In October, 32 new claims were registered with 1 lost time claim, compared with September where there were 23 new claims registered with 1 lost time claim.
- Current claims being managed by the Counties Manukau and WellNZ Case Managers are 140 in October with 104 being managed in September.
- Declined claims decreased in October (0) from September (11).

Key Health and Safety Risks and Current Project Activity

CM Heath Key H&S risks management update, including OHSS critical risks and key initiatives to reduce/manage risk.



CM Health Risk Matrix; for reference (note a table explaining frequency and consequence is included in the appendices)

LIKELIHOOD	CONSEQUENCE					
		Insignificant	**Minor**	**Moderate**	**Major**	**Catastrophic**
	Almost Certain				Critical	
	Likely			High		
	Possible		Medium			
	Unlikely	Low				
	Rare					

The following table contains the key OHSS risks and current activity.

Risk: Staff and others exposed to **Aggression and Violence** at the workplace			
Risk Rating: Critical		***Current***	Target
	Frequency	Almost Certain	Likely
	Consequence	Major	Major
Active Workflow			
• OHSS are actively involved in the working group that has been established to work through the recommendations from the Security Review that was undertaken in late 2019. Several OHSS projects including violence and aggression and lone work have strong links to this security review. • OHSS review and follow up with reported incidents of violence and aggression. • Code Orange incident trends are provided to OHSS. • WorkSafe has produced a guidance document on Violence in the Health and Disability sector. • OHSS are undertaking a gap analysis based on the WorkSafe document. • The upgraded incident and feedback system (SafetyFirst) has been available from 24 September 2020 and supports reporting and analysis of occupational violence.			
New Activity:			
Feedback has been sought and received on the V&A gap analysis; this feedback will form the next actions taken by the steering group. 20 DHB Managers are working on a V&A project			
Risk: Inability to manage the risk of harm from the work being carried out by **Contractors**			
Risk Rating: Critical		***Current***	Target
	Frequency	Possible	Unlikely
	Consequence	Major	Major
Active Workflow:			
• Contractors engaged by FEAM's are asked to provide a plan detailing the steps they will take to mitigate risks. • FEAM have continued with improvement of contractor health & safety management for capital projects including a particular focus in the following areas; inductions, contractors Job Safety Analysis, supervision and bi-annual performance reviews. • Further development of Confined Spaces policy & procedure, including permits to perform hazardous work. • Emergency and fire compliance are under review, with trial evacuations currently being conducted. • An engineering manual is in place (operating procedures). • Regular communication to team encouraging contractors to report incidents.			

New Activity:

healthAlliance and HealthSource have provided a breakdown of their contracting staff distribution as requested by CM Health Directors.

Meetings are underway with OHSS and H&S Managers from HealthSource and healthAlliance, note information will be shared as this becomes available.

healthAlliance contracting partners:				
Role/Position	**# of People in Role/Position**	**DHB Service Area where work is done**	**Location on DHB Site**	**Frequency on site**
On-Demand Engineers	8	Datacentres and hA Offices	Datacentres & hA Offices	1-2 days per week
End User Experience Managers	3	hA DHB Offices	hA DHB Offices	1 day per week
Implementation Move Technicians	2	All areas	All areas	2-4 days per week
Implementation Technicians	8	All areas	All areas	2-4 days per week
Service Delivery Technicians	9	hA DHB Offices	hA DHB Offices	2-4 days per week
Desktop Service Technicians	24	All areas	All areas	2-4 days per week
IS Trainers	2		Building 32 (Pink Palace) & Ko Awatea	1-2 days per week
IS Trainers	3		Building 32 (Pink Palace) & Ko Awatea	2-3 days per week
IS Trainers	2		Building 32 (Pink Palace) & Ko Awatea	4-5 days per week
IS Training Team Leaders	2		Building 32 (Pink Palace) & Ko Awatea	1-3 days per week
Network Engineer based in CMH	3	All Areas	Middlemore Hospital	Network Engineer based in CMH
Senior Network Engineer	6	Hub Rooms and Data Centres	All Locations	2 days per week each
Datacentre Engineer	1	Hub Rooms and Data Centres	All Locations	4 days per week
Senior Datacentre Engineer	1	Hub Rooms and Data Centres	All Locations	4 days per week
Telecommunications Engineer	5	All Areas	All Locations	3 days per week
Snr Telecommunications Engineer	1	All Areas	All Locations	3 days per week

Health Source contracting partners:

- 7 HealthSource employees working at the Manukau Super Clinic
- 24 HealthSource employees working at Middlemore Hospital

Risk: Musculoskeletal injuries sustained whilst **moving patients and other manual handling tasks**			
Risk Rating: High		***Current***	Target
	Frequency	Likely	Possible
	Consequence	Moderate	Moderate

Active Workflow:

- 1250 staff trained from the onset of the Safe Patient Moving project.
- Training ran on average 1 session per week. Training on hold during alert levels. ICU, Radiology and ED invited to training as of 2020. Work release to attend sessions problematic due to hospital demands.
- eLearning as a pre-training resource launched 1st of September 2020.
- Plans are underway to establish updated training from 30th of September 2020.
- Equipment procurement completed for Sara steady devices (sit to stand device).
- Equipment procurement continues including the HoverJack Floor retrieval kit, (delays due to international shipping secondary to Covid). Development of guidelines & supporting documents is now complete.
- Specialised equipment has been proposed and requested by SPHM Sub Committee (Regional RFP for Bariatric rental equipment & implementation of Single Patient Use slings).
- Reported incidents continue to be reviewed and monitored by both OHSS and SPMH teams.
- The Safe Moving & Handling of Patients communication topic was rolled out in July 2020.

New Activity:

- Training will resume on 15 September 2020.
- Educators attended an update day with colleagues from WDHB, where content of training programme was discussed, and techniques and equipment reviewed.
- To commence refresher training from 30 Sept. 2020 (content, educator availability, days and times). Scheduled to attend WDHB refresher training in September pending Alert levels.
- Orientation completed for 2 new SPHM Educators.
- Procurement for indicative equipment list in progress. Multiple new commodes coming into service. Indicative equipment list adjusted post interviews. Interviews are scheduled for September, to include Modules at MSC.
- Review of submissions relating to the supply of rental Bariatric Equipment for ADHB, CMDHB and WDHB completed. Site visits were completed in July. Preferred supplier identified.
- 4 Floor Retrieval kits received. Commenced rollout at MSC. Subsequent wards at MMH to follow.
- Support training for ASRU (Evacupods) commencing as part of fire evacuation plan. Training to start onsite.
- Commenced plan to develop CMH SPHM audit tool in conjunction with Research & Evaluation. Investigating tools, such as Trendcare, FOC, and Safe 365 that provide cross over data.

* this risk score is due for review and will be discussed at the next SPMH meeting

Risk: Lone Workers unable to access immediate assistance during an emergency situation

Risk Rating: High

	Current	Target
Frequency	Possible	Unlikely
Consequence	Major	Major

Active Workflow:

- Lone Worker Policy, and the new app standard operating procedures and the escalation process are being confirmed.
- Vendor contract is finalised with legal review for sign-off by DHB and Vendor.
- Training for the designated monitoring Security Guards underway early October.
- Pilot phase for Lone Worker app (Get home safe) commenced with community mental health teams.

New Activity:

- False alerts and handover times are being discussed as part of the pilot.
- A meeting is planned with Union partners to discuss Lone Work procedures.
- Lone work procedures on Paanui pages will be discussed including escalation processes with Police.

Risk: Wellbeing of staff adversely affected by aspects of work

Risk Rating: High

	Current	Target
Frequency	Likely	Possible
Consequence	Moderate	Moderate

Active Workflow:

- EAP is well established with CM Health including onsite clinics and external counselling. OHSS have regular meetings with the EAP organisers to discuss trends and support activities.
- CM Health has a wellbeing page, resources and tools on Paanui to support staff welfare.
- EAP have set up an additional referral program for CM Health with highly experienced counsellors who are available to provide support for managers and leaders in regards to any managerial challenges they might experience in their role.
- EAP have increased the facilitated and targeted sessions where required across CMH service areas. These sessions have been well received from staff

New Activity:

Schwartz Rounds

The inaugural Schwartz Round has been booked to occur at the December Grand Round on Thursday 17 December at 12:15pm in Lecture Theatre 3. Schwartz Rounds are a multidisciplinary forum where caregivers discuss the emotional and social issues that arise in caring for patients. In contrast to traditional medical rounds, the focus is on the human dimension of medicine. Caregivers have an opportunity to share their experiences, thoughts and feelings on thought-provoking topics drawn from actual patient cases.

Wellbeing Index

Implementation is planned for Allied staff, probably in December.

Patient Safety Day

EAP will be in attendance at CM Health for this initiative.

Risk: Staff experience **stress/fatigue** in the workplace			
Risk Rating: Critical		***Current***	Target
	Frequency	Almost Certain	Likely
	Consequence	Moderate	Moderate

Active Workflow:

- Workers are encouraged to report low staffing, stress and fatigue in RiskPro to enable managers to follow up.
- Tools such as Trendcare has made much more visible and transparent at what points in the day teams on the wards are feeling stressed or pressured and Middlemore Central is able to work with those wards to move staff around to relieve that pressure.
- CM Health have begun offering 'Team Wellbeing Check-ins' for teams. This is a facilitated discussion that a team attends and participates in together. The check-in is particularly helpful after a prolonged period of stress, such as experienced during COVID-19; and can also be part of our support to staff following a traumatic episode, such as the Whakaari eruption. We have partnered with EAPworks to deliver these sessions.
- CM Health has launched Leading Wellbeing at Work - Webinar which is a new programme, designed to equip managers and leaders to recognise and respond supportively to staff experiencing mental health challenges in the workplace. It is being run by Blueprint for Learning, who has previously delivered Mental Health 101 training to Counties staff.
- Planning is well underway to launch Health Round Table Workforce Well-Being Index for all nurses and HCA staff in December. It was launched to SMOs earlier this year.
- We commenced a new course on addiction: Addiction 101 is designed to increase awareness and reduce stigma associated with addiction – both at work and everyday life. Due to COVID-19 it is being run as a webinar and is being co-facilitated by someone who has lived experience of problematic substance use, and someone who has clinical experience working in addiction services.

New Activity:

Stress First Aid planning is underway as a pilot in CM Health in Q2 2021.

Risk: Staff are exposed to **blood and body fluid (BBFE)**			
Risk Rating: Critical		***Current***	Target
	Frequency	Almost Certain	Likely
	Consequence	Moderate	Moderate

Active Workflow:

- Occupational Health Nurses with the support of the Physicians follow up with incidents of BBFE that are reported to ensure immediate actions are taken.
- Trends in BBFE are sent on to clinical leaders for learning's.
- An Occupational Health and Safety communication topic will be prepared for BBFE.

New Activity:

Risk: Exposure to **Infectious Diseases**			
Risk Rating: Critical		***Current***	Target
	Frequency	Almost Certain	Likely
	Consequence	Moderate	Moderate

Active Workflow:

- A Risk Assessment has been completed by OHSS
- Work procedures are in place across the service lines to assist in the risk of exposure to infectious diseases.
- OHSS manage the Vulnerable Workers database.
- PPE is approved by IPC and provided, a respiratory mask fit testing program is underway as an interim solution.
- COVID-19 related work has generated reviews of current Occupational Health processes including Vulnerable Workers, Contact Tracing and H&S Risk Assessments.
- Occupational Health Physicians are involved in national advisory groups and provide internal advice on the topic of infectious diseases

New Activity:

- The Vulnerable workers database is under review to ensure processes are adequate should COVID-19 levels increase.
- Respiratory Mask Fit Testing processes are being established within OHSS including on-boarding of the Fit Test team.

Risk: Staff and others sustain **slips, trips or falls** in the workplace			
Risk Rating: High		***Current***	Target
	Frequency	Likely	Possible
	Consequence	Moderate	Moderate

Active Workflow:

- Trends in slips, trips and falls (STF) from ground level incidents are monitored by OHSS.
- Specific actions are undertaken following STF incidents including reaching out to FEAMs and Cleaning managers to assess hazards as they arise.

New Activity:

Risk: Suboptimal evidence of adherence to **H&S legislative requirements** (legal)			
Risk Rating: High		***Current***	Target
	Frequency	Unlikely	Rare
	Consequence	Major	Major

Active Workflow (Safe365)

- Currently 30 Safe365 licences have been set up (as outlined above).
- The Safe365 information page on Paanui is in draft awaiting roll-out and will provide HSRs with links to resources and tips for increasing their compliance scores
- The worker induction booklet has been updated and rolled out.
- The OHSS team have carried out the annual self-assessment of the safety and injury management elements of the ACC audit in preparation for the ACC AEP audit which was postponed until February 2021.

New Activity:

- An internal OHSS audit program has been delayed due to COVID-19 activity however is in draft and will be sent to leaders for comment and approvals before the end of 2020.

Risk: Failure to have adequate identifiable **worker participation** in HSW management system (legal)			
Risk Rating: High		***Current***	Target
	Frequency	Unlikely	Rare
	Consequence	Major	Major
Active Workflow:			

- HSR training sessions have been completed.
- Work is progressing on a regional approach to establish a shared HSR training provider.
- OHSS send out H&S communications each month to HSRs for sharing with their colleagues.
- Communications include reminders when work area inspections are due.
- HSR's are invited to comment on documents OHSS are preparing and incidents that OHSS are investigating.
- HSRs are nominated to attend the ELT H&S committee have an agenda time to convey issues they wish to raise.

New Activity:

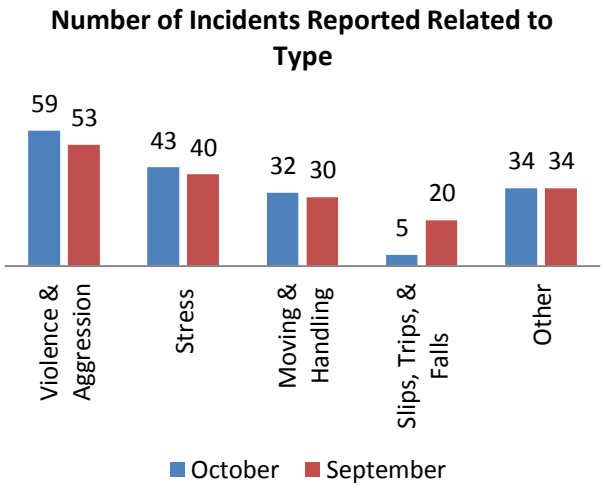
- Establishment of Health and Safety Star rewards programme.
- Health and Safety Noticeboard Competition is underway.
- Two additional HSR training session are planned for December 2020.

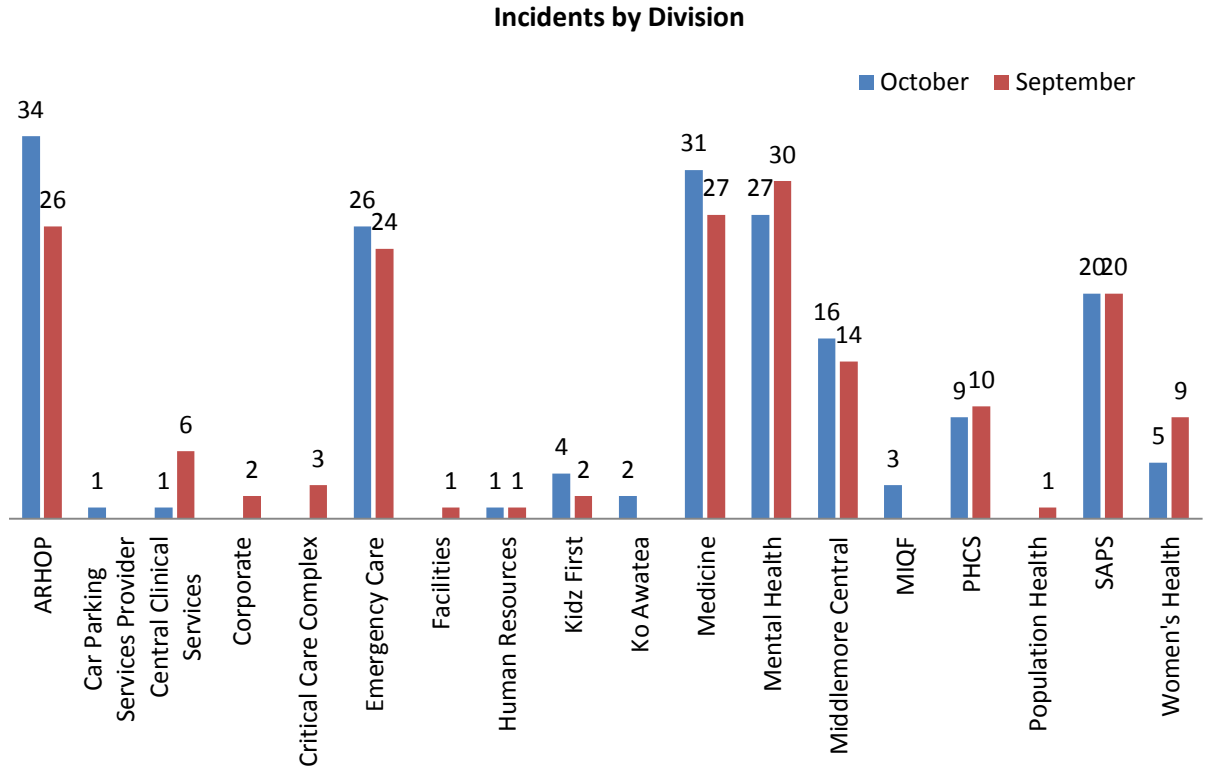
Reported Incidents

Monthly total of incidents reported in October (173) a slight decrease in comparison to September (177).

Data on Incidents reported:

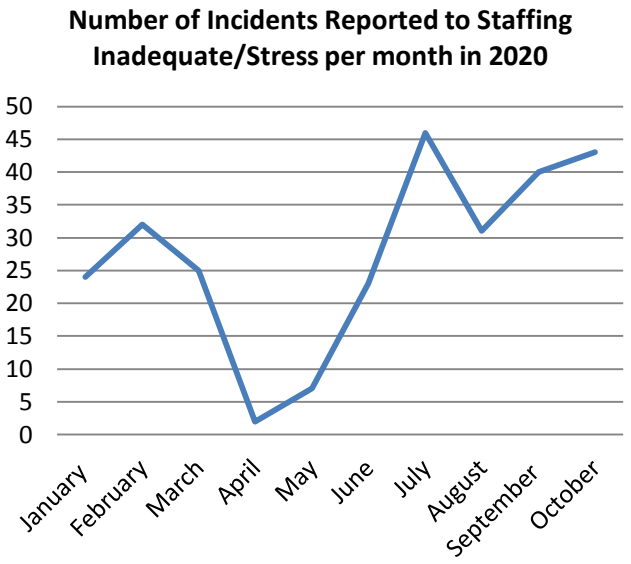
- **Aggression & Violence**: Remains in the top three incident rates. A slight increase in numbers reported for October (59) in comparison to September (53).
- **Stress**: October (43) indicates a slight increase from September (40), but remains an increase on August (31). Stress is reported predominantly in the area of short staffing.
- **Moving and Handling:** October (32) is a slight increase on September (30). The proportion related to having occurred during moving / handling of patients (22) remains high.
- **Slip/Trip/Fall:** October (5) indicates a significant decrease from September (20).
- **Others:** Figures remained stable for October (34) and September (34).

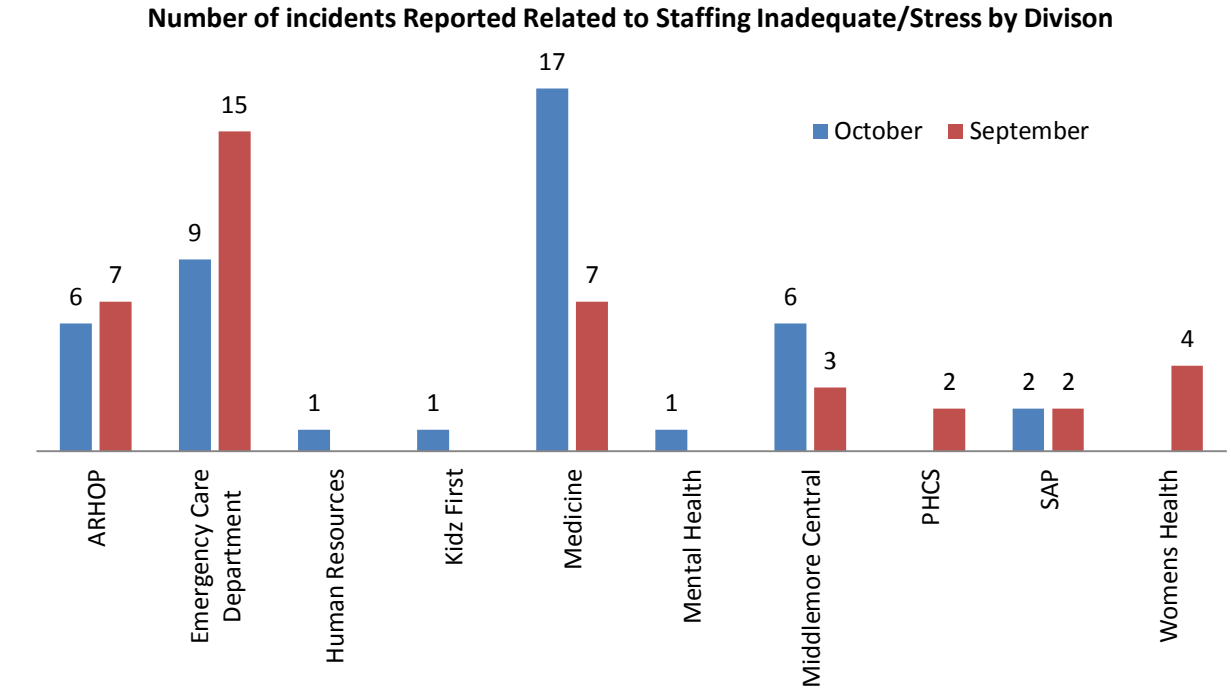




Staffing inadequate/unavailable, Stress

- Reports of stress in October (4) are a significant decrease from September (17).
- Reports of staffing inadequate or unavailable has increased significantly from October (39) to September (23).



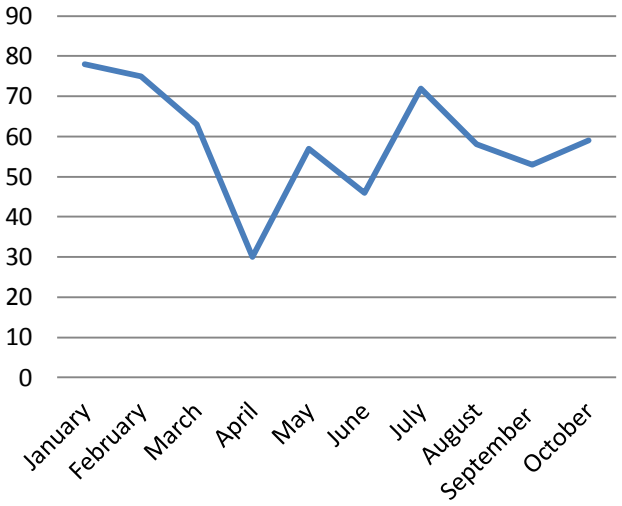


Aggression and Violence

- Aggression and violence monthly figures for October (59) have increased slightly from September (53).

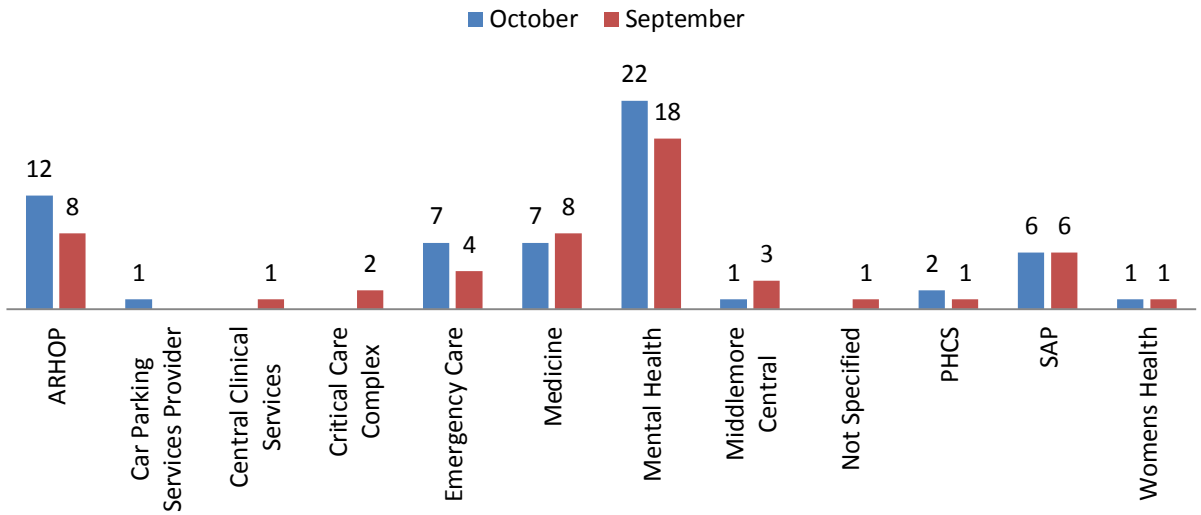
- ED 'Code Orange' data **– 13** incidents reported in September, **9** in October which was the same as **9** incidents reported in August.
- The October 2020 figure is lower than October 2019 (21). Historically there has been an increase in Code Orange incidents reported over the October to December period.
    - 2 incidents were reported as having alcohol as a potential causative factor each month, 3 reported drugs as a potential causative factor in September and 1 in October.
    - Of 'Code Orange' incidents reported to date the area Waiting Room / Triage has seen the most reported incidents which is consistent with August. Followed by Adult assessment and Medical Assessment/Monitored, Resus areas.

Number of Incidents Reported Related to Aggression & Violence per month in 2020



Incident Classifications	Oct	Sept
Abuse - verbal	3	1
Access/exit unsecured		1
Assault – physical	22	21
Assault - sexual	1	
Assault – verbal/ gesture	4	5
Behaviour – aggressive/ threatening	17	13
Behaviour – harassment	2	3
Behaviour – inappropriate	6	7
Behaviour – violent	1	
Property damage/vandalism		
hit/bitten/scratched by person unintentionally	2	2
Threat of violence	1	

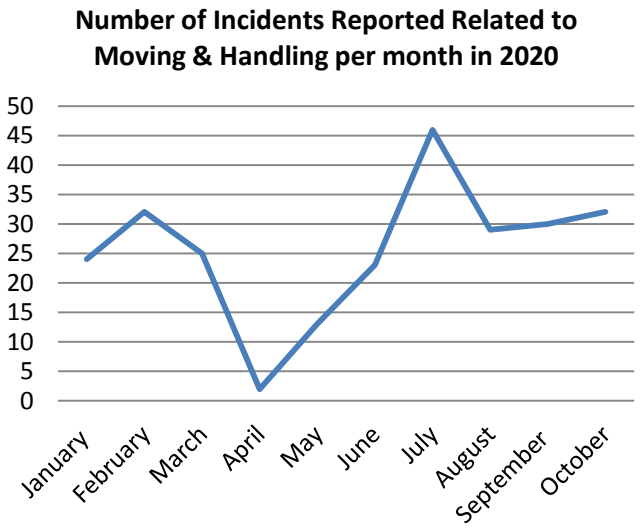
Number of Incidents Reported Related to Aggression & Violence

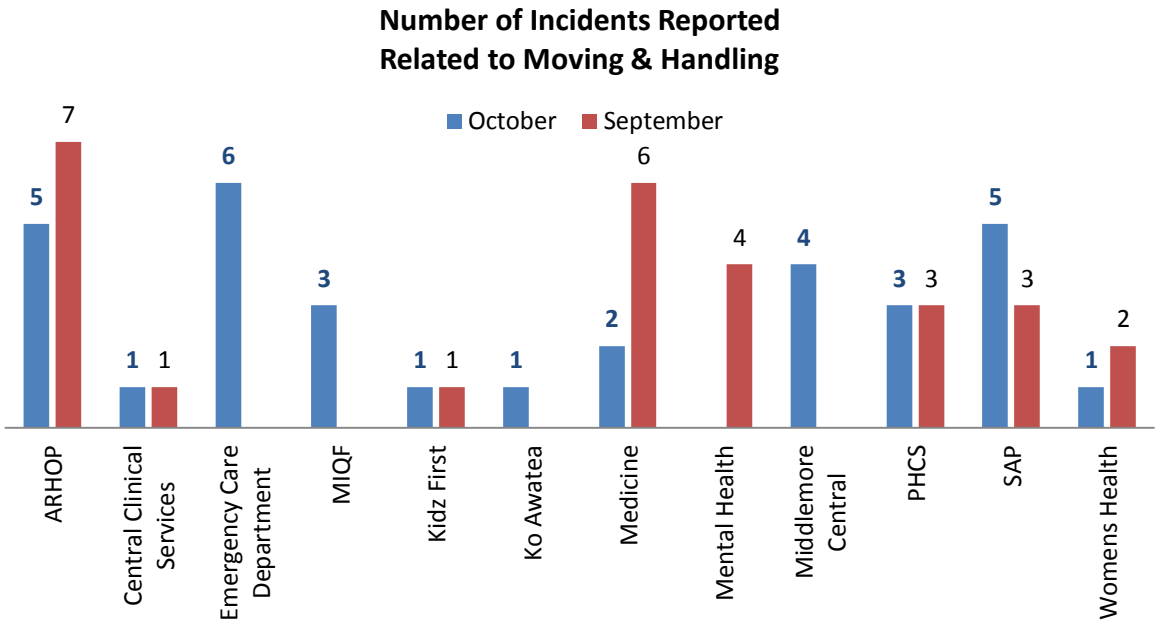


Moving and Handling

October (32) figures show a slight increase from September (30), however a decrease from July (46).

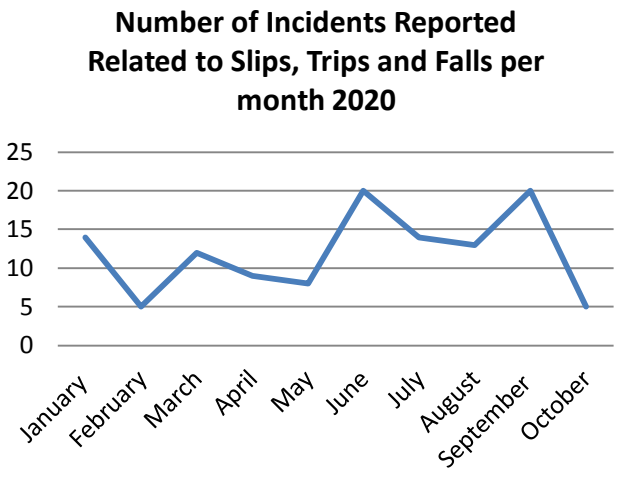
- 22 injuries are reported as occurring while moving / handling a patient.

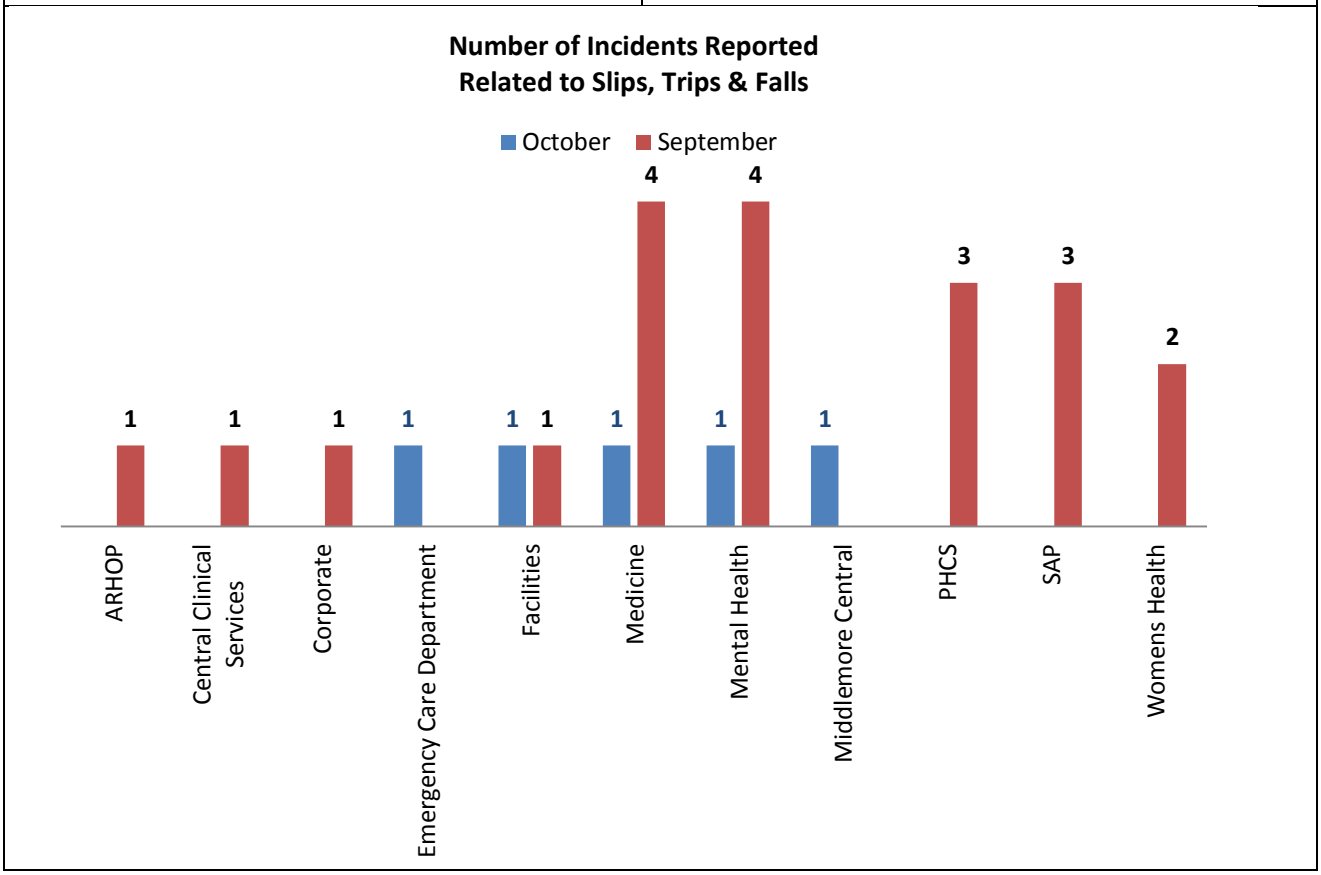




Slips, Trips and Falls

- Slips, Trips and Falls monthly figures in October (5) were a significant decrease from September (20).

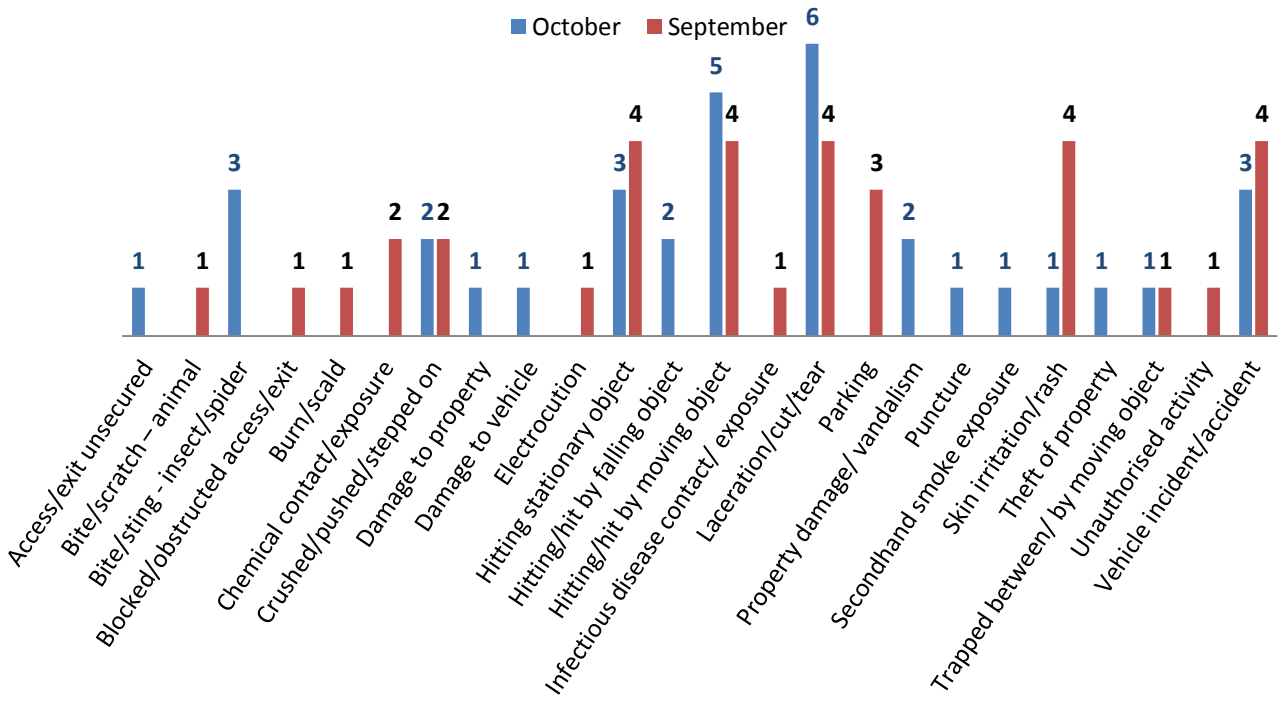




Other incidents

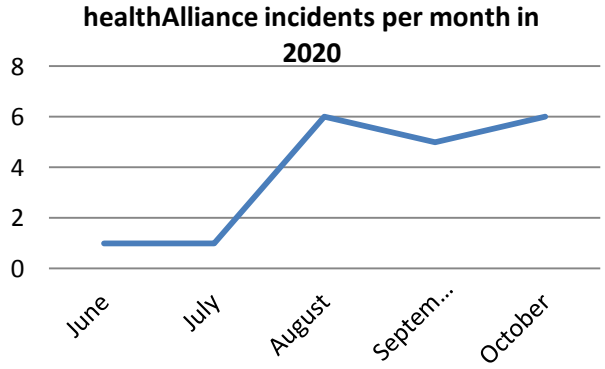
Other incidents October (34) remained equal with September (34).
Six incidents in October were reportedly caused by lacerations/cut/tear and (5) by hitting or being hit by moving objects.

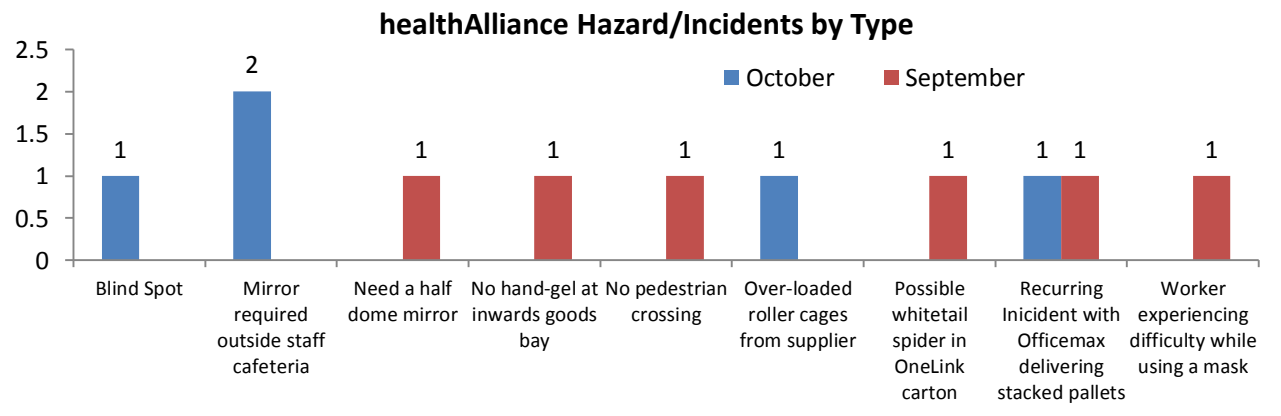
Number of Incidents Reported Other than Those in Five Identified High Risks



healthAlliance Incidents

Hazards and incidents are reported through to the CM Health contractor account manager for action each month.
Hazards/Incidents reported figures for October (6) remained stable with September (5).

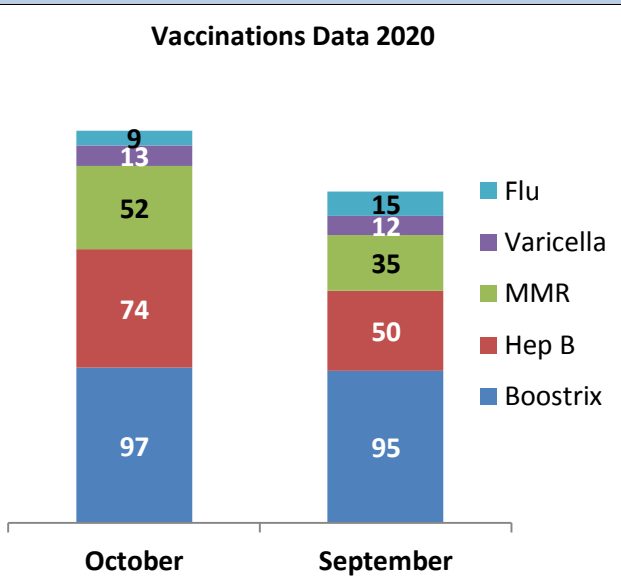




Occupational Health Service Update

Vaccinations:

Vaccinations continue to be administered as part of the pre-employment screening process. Existing employees are recalled to clinic to complete vaccination series and receive boosters.
Vaccination clinics have returned to normal during October with many employees requiring multiple vaccinations. This is why the number of clinic appointments is less in October than in September, but the number of vaccinations administered is higher.
Occupational Health is continuing to see a significant number of new employees with no immunity to diseases such as measles. This is reflected in the number of vaccinations administered.



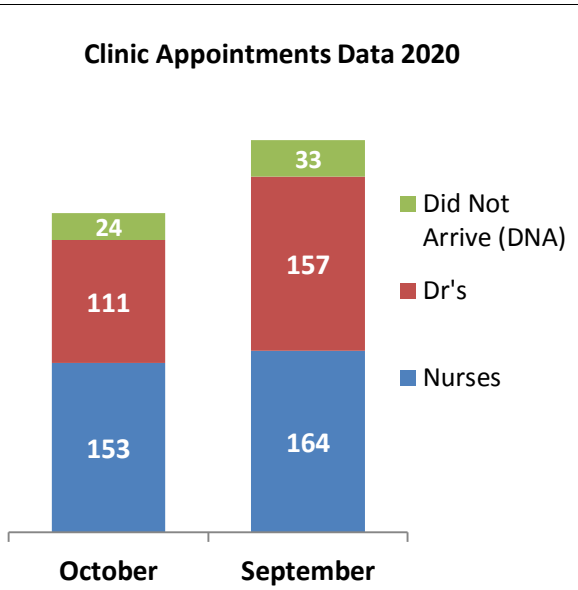
Clinic Appointments:

The OHP clinic time has been impacted by their attendance at regional and local meetings such as CTAG and the Occupational Health Physician Regional Meetings.
Complex cases require additional OHP time and are not reflected in the number of clinic appointments.

There were 153 OHN clinic appointments in October and 164 in September.

These figures include business as usual appointments along with the team's on-going COVID-19 response.

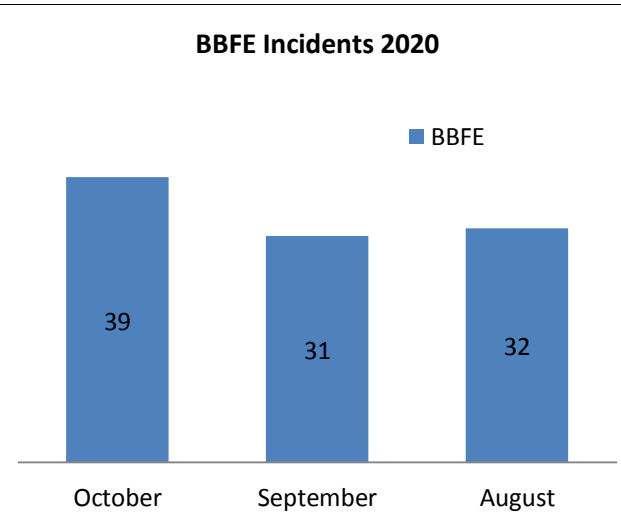
There were 24 DNA's for October and 33 in September.



Blood Bodily Fluid Exposure:

BBFE for October (39) is a slight increase from September (31). BBFE incidents are investigated and managed by the Occupational Health nursing team.

The Occupational Health Team has received feed-back from one of the H&S Representatives that the BBFE process is easy to follow and that staff received contact from OHSS in a timely fashion.



Manager Referrals:

Manager referrals for October (26) is a decrease from September (36).

Contact Tracing:
There were two contact traces conducted during September. Two contact traces occurred during October

The Occupational Health Nurse Advisor is continuing to liaise with WDHB, ADHB and ARPHS to utilise the MoH's National Contact Tracing System (NCTS). This is in an effort to establish a regional approach to supporting DHB's for CT work (COVID-19).

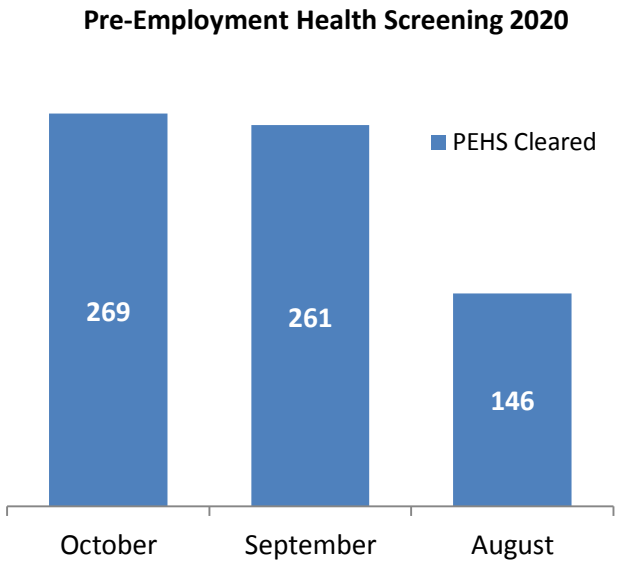
The CM Health written process for CT is being updated to reflect the regional approach and is currently under consultation with IPC.

Pre-employment Health Screening:

Pre-employment Health Screening for October (269) and September (261) have significantly increased since August (146).

Of the reported Pre-employment Health Screening figures there were significant amounts for Managed Isolation Facilities and Quarantine Facilities. These were 74 for October and 77 for September.

There is additional screening required by the OHN for the MIFQ Pre-employment Health questionnaires. This is in line with the Ministry of Business Innovation and Employment requirements.



Appendix

1. OHSS Risk Matrix;

OHSS Consequence table (for reference)

Consequence	Safety / Health Staff, public
Insignificant	Work related injury requiring no intervention or treatment. No time off work required.
Minor	Minor work related injury or illness requiring minor intervention. May require time off work for <7 days.
Moderate	Moderate work related injury or illness requiring further intervention. Requiring time off work for >7 days.
Major	Death / Major work related injury or illness leading to long-term incapacity / disability. Admission to hospital for more than 24 hours
Fundamental/ Catastrophic	Incident leading to death of individual or several people with direct causation /negligence. Multiple permanent injuries or irreversible health effects. Potential for serious harm / death resulting from systemic issue.

OHSS Likelihood table (for reference)

Probability	Definition
Almost Certain	*(Certain – continuous) Will occur in most circumstances (Once a day or on the job all the time)*
Likely	*(Likely) Will occur in some circumstances (Once a week)*
Possible	*(Possible) Should occur at some time (Once a month < 6 Months)*
Unlikely	*(Unlikely) Could occur at some time (Once every 6 months < 2 Years)*
Rare	*(Rare – very rare) May occur in exceptional circumstances (2 years +)*

Information Paper
Counties Manukau District Health Board
Corporate Affairs and Communications Report

Recommendation

It is recommended that Board:

Receive the Corporate Affairs and Communications Report for the period 1 October – 15 November 2020.

Prepared and submitted by: Donna Baker, General Manager Communications and Engagement and Alan Greenslade, Acting Director Strategy and Infrastructure.

Purpose

This paper provides an update on Corporate Affairs and Communications activity for the period 1 October – 15 November 2020.

COVID-19 Response

IMT

The General Manager Communications and Engagement continued to provide Public Information Management (PIM) support to the CM Health Incident Management Team (IMT). During this time the Auckland region transitioned from Alert Level Two to Alert Level One, and the Middlemore Hospital Response Level changed from Yellow to Green. Visiting restrictions and screening have remained in place.

External Comms

Media Enquiries

Although the General Election dominated the news cycle, during the reporting timeframe we continued to receive numerous and varied queries from media outlets. The main areas of media interest were patient status requests (6), diabetes (3), COVID-19/MIQ (3), and the Emergency Department (3). A total of 48 media enquiries were received, answered and closed.

Proactive Media

A total of 16 proactive stories were promoted through various CM Health media channels. These included features on:

- Te Ranga Ora Timatanga initiative
- Increased visibility of Te Reo signage in Middlemore Hospital
- New CM Health roles helping Pacific patients impacted by COVID-19

- CM Health psychiatrist Dr Shishir Regmi
- Facilitation of General Election voting options for patients.

Media Training
A media training workshop was facilitated in late October with the following CM Health staff:

- Richard Wong She, Consultant – Plastics and Burns
- Ian Soosay – Clinical Director, Mental Health and Addictions
- Siale Foliaki – Clinical Director of Allied Health, Consultant Psychiatrist
- Melodie Barr – Clinical Director of Allied Health Scientific and Technical
- Penny Magud – General Manager Locality Services

Feedback from attendees continues to be exclusively positive and a four-hour investment of their time provides significant value and benefit to both the individual, in terms of understanding the media and building their profile in a productive manner, and the organisation through proactively protecting its reputation. Encouraging CM Health to identify key people to attend this training and facilitate their attendance continues to be in the organisation's interests.

Whaakari/White Island
With media interest in the upcoming one-year anniversary of the Whaakari/White Island tragedy, we continue to facilitate interviews with staff involved in treating the victims for feature stories, scheduled to be aired close to the anniversary date.

Bariatric Surgery Story
Following 18 months of documenting a CM Health bariatric patient's journey, the Sunday television show aired their story on 11 October. Prior to its airing, the show's producer informed us that the story would address issues such as funding shortages and a paucity of psychological support for bariatric patients. Accordingly, we developed a statement in the event of media enquiries and provided a briefing paper to the Minister of Health and his office.

The story was well-balanced and its larger points focused on short-comings at a governmental level, while showing CM Health as doing its utmost for patients while operating under constrained circumstances.

Strategic Planning - Facilities Modernisation
External Comms is working with this team to develop and implement an overarching strategic communications programme that will enable us to tell the story behind our facilities investment strategy, plans and outcomes in a way which effectively engages our community and other key stakeholders.

There is a significant programme of work happening in this space and a number of good stories that demonstrate how CM Health can connect, and has already connected, with our community on health issues.

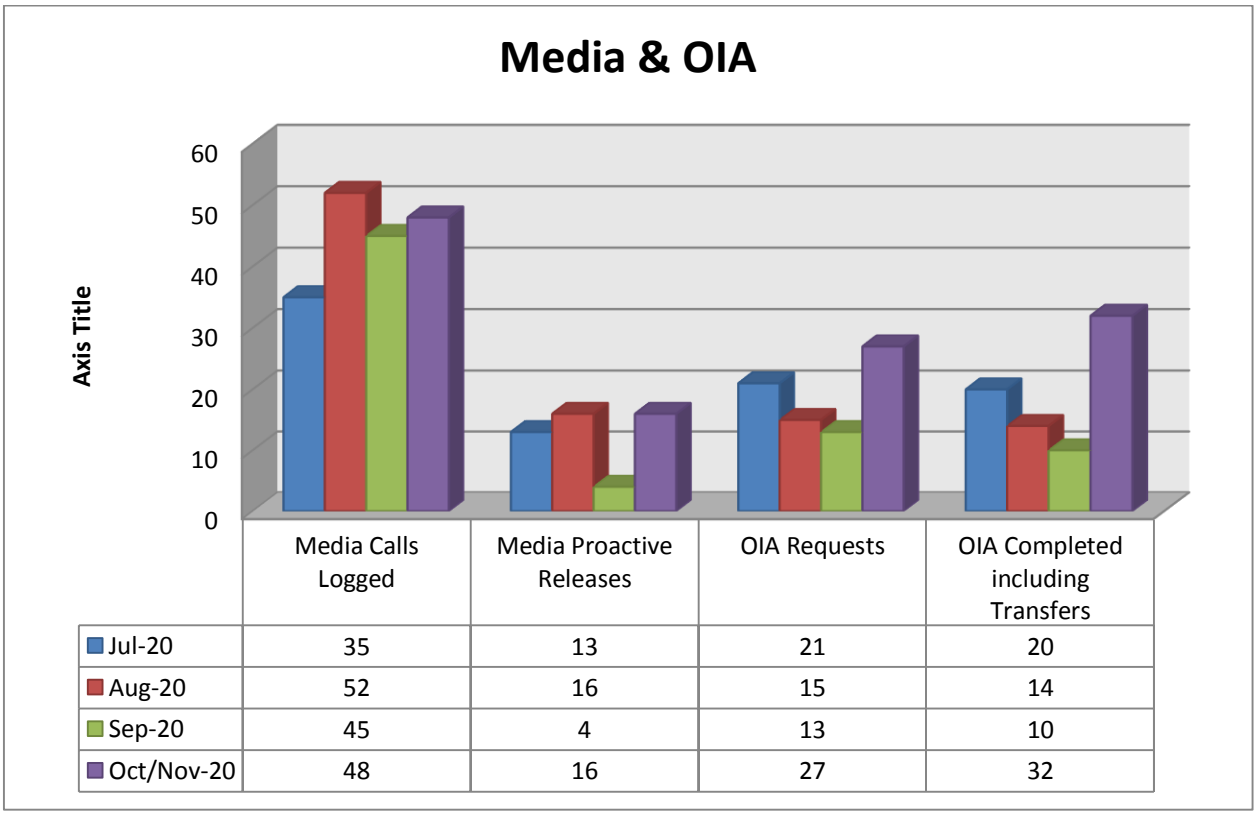
Mental Health Services Awareness – Asian Communities
Raising mental health (MH) service awareness among our wider Asian communities has been identified as an overlooked but much needed area of focus within Counties Manukau, due in large part to both the stigma that surrounds MH in these communities and a lack of understanding of the options available. As such, we are working with the MH service to implement a communications plan which will enable us to better connect with these communities by utilizing consistent, transparent messaging and the wider community distribution networks/channels we have available to us following our COVID-19 outreach..

Official Information Act (1982)
Agencies have 20 working days to advise a decision on release of information requested under the Official Information Act (OIA). This means that there is a rolling response from receipt in one month to response in next month. Requests will vary in their complexity, scope and considerations.

Over the month of October and first 15 days of November 2020 we received 29 OIA requests, the majority of which were from media outlets. No parliamentary questions were received over this time.

Thirty OIA requests were closed over this period. This includes three OIA requests related to COVID-19 or Managed Isolation & Quarantine (MIQ), which were transferred to the Northern Regional Health Coordination Centre (NRHCC). An additional two requests were transferred to other agencies.

Request Received OIA & Parliamentary Questions (PQ) for 1/10/20-15/11/20		
Division	**OIA**	**Parliamentary Question**
COVID-19	3	
CEO Office	1	
Central Clinical Services	1	
Emergency Department/Middlemore Central/Critical Care Complex	3	
Finance	5	
Feedback Central	1	
Human Resources	4	
Kidz First	1	
Medicine	1	
Mental Health	2	
Primary Care	1	
Surgical	2	
Women's Health	2	
Transferred to other agency	2	



	Media Calls Logged	Media Proactive Releases	OIA Requests	OIA Completed including Transfers
Jul-20	35	13	21	20
Aug-20	52	16	15	14
Sep-20	45	4	13	10
Oct/Nov-20	48	16	27	32

Internal Comms

Privacy Week and Privacy Act changes

Support was provided to the Privacy Team on this campaign, focusing more on the Privacy Act changes that come into effect from 1 December than simply awareness of the week itself.

Patient Safety Day

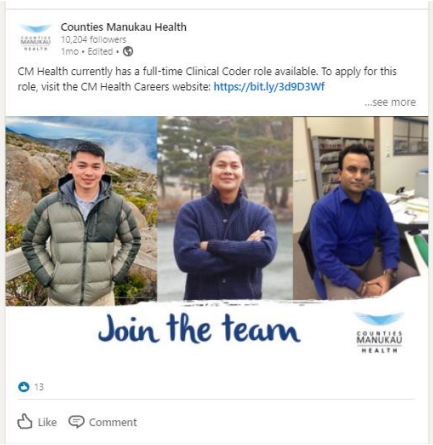
Working closely with the Patient Experience Team, Internal Comms provided support for planning and messaging for Patient Safety Day. Collateral was produced for teams participating in the event, such as the Sensory Modulation display.

Organisational Development

Uptake of the Nursing Wellbeing Index app remains mixed. Further editorial advice has been provided to promote the app, particularly during the Patient Safety Day event. Showcasing staff through displays across Middlemore has been well received, with positive feedback.

Human Resources

During this period, several advertisements were developed for the Human Resources (HR) team, enticing potential employees to consider working for CM Health. Those advertisements featuring actual staff registered higher engagement than the ones without staff on social media channels.



PAANUI – Our People

For full stories please use link: https://cmhealth.hanz.health.nz/News/default.aspx

- **"You are our sunshine"**: Joe Henry's farewell as kaumatua for Mental Health and Addictions Service
- **Ivan Trethowen**: Introducing our new Head of Security and Organisational Resilience
- **Dr Shishir Regmi**: Spotlight on Nepalese psychiatrist

Internal Comms Support for Campaigns & Project ***Collateral Suites*Profiling Teams*Communications Plans*Promoting Events*Workshops*Creating Surveys***			
World Stroke Day	World Sight Day	Malnutrition Week	Staff Forums
Cyber Safety Week	International Day of Radiology	International Allied Health Professions Day	Language Weeks
Pink Shirt Day	CM Health Disability Strategy	Organisational Development	Scott Building Completion
Privacy Week	NetworkZ	Healthy Together Technology	

Stakeholders and Community

Celebrating Language Weeks

Niue Language Week: This years theme was '*Faliki e tau momoui he tau atuhau aki e Vagahau Niue,*' translated into English means 'Lay the foundations – give rise to Vagahau Niue for generations'. This year we profiled two staff members, Manogi Kauie and Jenna Jacobsen Toeono. Read their stories here.

Tokelau Language Week: The theme for this year was '*Apoapo tau foe, i nā tāfea i te galutau. Ke mau mai, ke mau mai,*' which in English means 'Never give up hope, even amidst chaos and uncertainty. Stay united, stay strong'. This year we profiled Dr Epenesa Iosua with a video. Watch here.

Asian Health

A video with Chief Executive Margie Apa was produced to thank everyone for their involvement in the Flu Fighters programme as a certificate ceremony couldn't be held due to COVID-19 restrictions. Please see here for the video.

Diwali was celebrated across CM Health sites, with competitions, eCald cultural training, special menus in the Manukau Health Park and Middlemore Hospital staff cafeterias, and profiles and videos of staff on the website and social media channels.

Screening Programmes

Breast Screening

October was Breast Cancer Awareness Month, with a focus on Maaori waahine. Content to promote the month was pushed across our internal channels and externally through social media.

MMR 15-30 Vaccination Catch Up Programme

Initial promotional activity has focused on raising staff and community awareness. This has been done through a range of collateral, including posters, billboards, screensavers and social media posting.

Alcohol Harm Minimisation

Following the Uncap Our Potential campaign, clinical resources have been developed to use in both hospital and primary care settings using the slogan "We don't always know what's under the lid" to encourage conversations with patients about alcohol.

Campaigns & Projects Collateral Suites										
Business Group	**Scope**	**Pull Up Banners**	**Posters**	**Brochure**	**Billboard**	**PAANUI Screensaver**	**PAANUI Sliders**	**Social Media Webinar CM Website**	**Photo Shoot**	**Video**
Patient Safety Day	Campaign Promotion		☑			☑				
Pink Shirt Day	Promotion							☑		
Niue Language Week	Promotion					☑				
Tokelau Language Week	Promotion							☑		
Diwali	Campaign Promotion					☑		☑		☑
LARCs	Promotion		☑							
Breast Screening Awareness	Campaign Promotion		☑			☑		☑		
Interpreter Service	Promotion		☑							
Research Week	Campaign Promotion						☑	☑		
MMR 15-30 Catch Up Programme	Campaign Promotion		☑		☑	☑		☑		
Alcohol Harm Minimisation	Promotion		☑							

Digital Channels
CM Health Video Register

CM HEALTH VIDEOS

	Video	Channel	Date Published
1.	PICC Trouble shooting-	KA Learn	Nov 16, 2020
2.	De-accessing ICVD	KA Learn	Nov 16, 2020
3.	Accessing ICVD	KA Learn	Nov 15, 2020
4.	CVL Dressing and Injection Port	KA Learn	Nov 15, 2020
5.	Blood Culture	KA Learn	Nov 15, 2020
6.	Direct Draw (Push Pull) Method	KA Learn	Nov 15, 2020
7.	Syringe Draw (Push Pull) Method	KA Learn	Nov 15, 2020
8.	Celebrating Diwali 2020 - Dance	Facebook	Nov 12, 2020
9.	Look at You, - Aroha Atu, Aroha Mai (English)	External	Nov 9, 2020
10.	Margie - Thank You	Facebook	Nov 4, 2020
11.	Research Week 2020 - Grand Round	Paanui	Oct 29, 2020
12.	Research Week 2020 - 15-10-2020 - Part 2	Paanui	Oct 29, 2020
13.	Research Week 2020 - 15-10-2020 - Part 1	Paanui	Oct 29, 2020
14.	Research Week 2020 - 14-10-2020 - Part 2	Paanui	Oct 29, 2020
15.	Tokelau Language Week 2020	Facebook	Oct 29, 2020
16.	Research Week 2020 - 14-10-2020 - Part 1	Paanui	Oct 29, 2020
17.	HAC - Tiaho Mai Virtual Tour	Event	Oct 26, 2020
18.	Research Week 2020 - 13-10-2020 - Part 1	Paanui	Oct 26, 2020
19.	Research Week 2020 - 13-10-2020 - Part 2	Paanui	Oct 26, 2020
20.	A Maaori Response to COVID-19 - CMH Health	External	Oct 22, 2020
21.	Niue LW 2020 fun facts video	Facebook	Oct 21, 2020
22.	Research Week 2020 - Closing Ceremony - Ashley Bloomfield	Paanui	Oct 18, 2020
23.	A Child's Visit to Manukau Surgery Centre	External	Oct 18, 2020
24.	Pink Shirt Day 2020	Facebook	Oct 18, 2020

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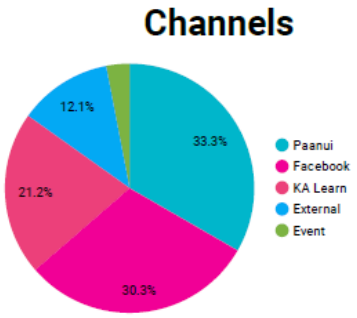
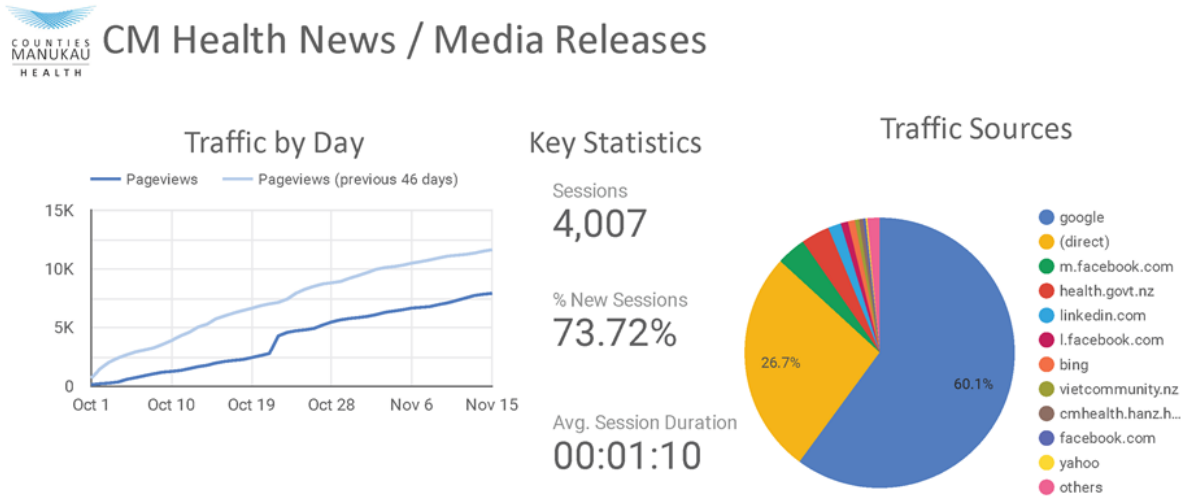


Videos Produced
33

Website (www.countiesmanukau.health.nz)
With Auckland moving to Alert Level 1 and fewer updates about COVID-19 testing centres, we have noticed a dip in metrics to our website. Despite this change the pop-up testing centres was still our most sought-after news story for this period.

News / Media Release Readership



Popular Articles

	Page Title	Pageviews	% Unique Pageviews	Avg. Session Durati...
1.	Seven new pop-up COVID-19 Testing Centres open in Auckland | Counties M...	1,018	89.78%	00:00:47
2.	List of designated practices for COVID-19 testing released, new Rosedale po...	310	83.87%	00:00:58
3.	Visitor car park rates increase at Middlemore Hospital | Counties Manukau ...	248	82.26%	00:01:24
4.	It's more than a job, it's my vocation | Counties Manukau Health	243	76.54%	00:01:02
5.	Cervical smear coordinator bridging the cultural gap around healthcare for ...	161	88.82%	00:00:35
6.	Tu ke Mau ti Fakamatalahi ko au koe Niue - Stand Tall and Be Proud, I am a ...	132	86.36%	00:01:38
7.	CM Health Asian staff reflect our diverse community | Counties Manukau He...	129	83.72%	00:01:25
8.	'Kia marama te Kupu' Understand the Word as CM Health installs te reo Ma...	110	97.27%	00:00:21
9.	New Dental facility for Counties Manukau | Counties Manukau Health	109	77.98%	00:01:57
10.	Middlemore's visitor policies slightly relaxed under COVID Level 1 | Counties ...	106	82.08%	00:00:53
11.	2020 General Elections - Process and Voting for Patients | Counties Manuka...	101	90.1%	00:00:39
12.	Where to get tested in Auckland this Labour weekend | Counties Manukau H...	99	90.91%	00:00:40
13.	Cleaners busy keeping Middlemore Hospital safe | Counties Manukau Health	85	88.24%	00:01:15
14.	Two additional Community Testing Centres open on the North Shore | Count...	82	95.12%	00:00:51
15.	News - By Communications Team | Counties Manukau Health	69	86.96%	00:00:00
16.	CM Health recognises International Infant and Baby Loss Awareness Day | C...	61	93.44%	00:00:06
17.	Meet SIMeon from NetworkZ | Counties Manukau Health	57	85.96%	00:00:18
18.	New Community Testing Centres (CTCs) opening in metro Auckland | Counti...	50	90%	00:00:59
19.	New CEO announced for Counties Manukau Health | Counties Manukau He...	49	75.51%	00:00:48
20.	Counties Manukau Health develops ground-breaking primary and communi...	49	77.55%	00:01:42

Figure 1Web Site Data Metrics from Google Analytics

Social Media

Our social media remained steady throughout this period, with the exception of Facebook which saw a drop in metrics due to fewer boosted posts. On this channel, we saw a dip in reach and follower growth, as is expected after a strong month. LinkedIn and Instagram continue to grow at rates that we expect to see.

	Total Followers	Follower increase	Messages Sent	Impressions	Impressions per Post	Engagements (incl. post clicks)	Engagements per Post	Post Clicks
CM Health Facebook	20,525	0.60%	40	79,480	1,987	6,341	158.53	27,009
CM Health Instagram	1,276	4.23%	27	11,364	421	833	30.85	363
CM Health LinkedIn	10,206	1.74%	32	57,073	1,784	10,087	315.22	7,571

Figure 1 Summary of Reach and Engagement Metrics for each social media channel

Audience Growth

	Totals	Change (vs. last growth)
Total Fans	34,883	
New Facebook Fans	123	-25.14%
New LinkedIn Followers	175	-129.11%
New Instagram Fans	54	-86.63%
Total Fans Gained	352	-8.81%

Figure 2 Audience Growth Overview by social media channel CM Health Facebook

Facebook Comparison (CMDHB/ADHB/WDHB)
We're adding something new to the report, a comparison between the CMDHB, ADHB, and WDHB's Facebook channels. This comparison will look at the publicly visible data associated with the performance of each Page's performance across the reporting period.

It is worth noting that as CMH has roughly twice the audience of the ADHB and WDHB Page's, we're almost a victim of our own success as the Facebook algorithm is designed to optimise growth.

This means that having a larger audience, Facebook organically delivers our content to roughly half that of smaller pages like ADHB and WDHB. Please keep this in mind while viewing the graphs.

Top 5 Posts
This section is a raw-data dump of the five best performing posts from each channel, sorted by total engagement.

Reactions vs. Number of Posts
This section looks at the comments, shares, and reactions per post. Looking at the graph you can see that Auckland is the clear "winner" this period, with engagement greater than WDHB & CMDHB.

Auckland's most popular post, a waiata about the importance of wearing a mask, was shared ~800 times and heavily inflated their average number of shares this period. You can see this reflected in the purple section of the bar chart, which is significantly bigger than ours/WDHBs.

This is likely to be the most dynamic section in each report and will give you the most 'at a glance' indicator for how well a particular channel has performed in any given reporting period.

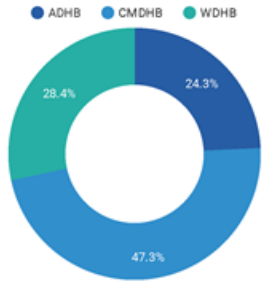
Engagement Rate (per post)
This is the rate at which (on average) a channel's post has been engaged with. This is representative of the size of the audience (eg: 21% of the audience has engaged with any given post).

In this section you will typically see CMH at the lower end, this is due to the fact that the algorithm organically pushes posts at half the rate of our smaller counter-parts, as mentioned previously.

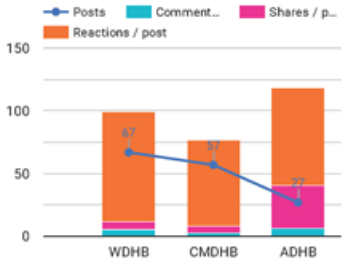
Again, you see Auckland's average engagement being boosted by an unusually high-performing post. CMH would sit somewhere in the middle if you (roughly) double the numbers to adjust for the engagement handicap we experience, leaving WDHB in third place for this reporting period.

Facebook Comparison

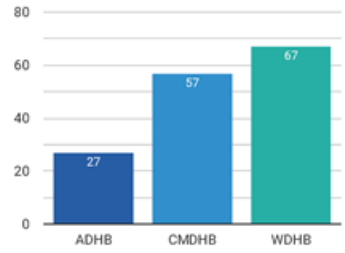
Audience share



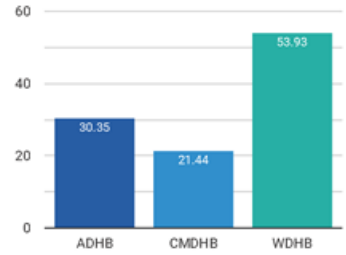
Reactions vs. Number of Posts



Posts this month



Engagement rate (per post)



CMDHB Top 5 posts

Post Message	Likes / Reactions	Comments	Shares
As we're nearing the end of Tokelau Language Week, our Dr Epenesa Iosua shares what's most important...	443	14	39
We have two exciting opportunities for Population Health Advisors in our Alcohol Harm Minimisation T...	281	5	20
Our Pharmacy team wanted to acknowledge all the work orderlies do in the pharmacy space, so they dec...	282	17	7
Fakaalofa atu! It's Niue Language Week! This year's theme is Faliki e tau momoui he tau atuhau aki e...	202	9	35

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ADHB Top 5 Posts

Post Message	Likes / Reactions	Comments	Shares
Join us by singing and sharing 'Tō mask e kare'. Me mahi tahi tonu tātou mo te oranga o te katoa |...	626	69	814
Last night our Chief Nursing Officer Margaret Dotchin was awarded Te Tohu Ratonga Tūmatanui o Aotear...	252	53	8
Here's a #sneakpeak inside the new Taiao ora	Ward 51 at Auckland City Hospital – clinically design...	215	9	8
Today is Thank Your	187	16	15

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WDHB Top 5 Posts

Post Message	Likes / Reactions	Comments	Post shares
Congratulations to House Officer of the Month for September - Dr Kenji Kawamura ✨🎉🏆 Dr Kawamura was...	374	51	3
✨💕 Happy Pink Shirt Day whanau! 💕✨ We care for the largest district population in NZ and employ aro...	312	7	14
Today is World Allied Health Professionals Day 2020! ✨🎉 There are at least 43 professions that	298	9	12

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CM Health Facebook

Pink Shirt Day and Tokelauan Language Week messaging performed very well on Facebook towards the end of October. It is a notably high month for engagement on Facebook, with over 25,000 post clicks and our two top posts receiving >20% engagement rates.

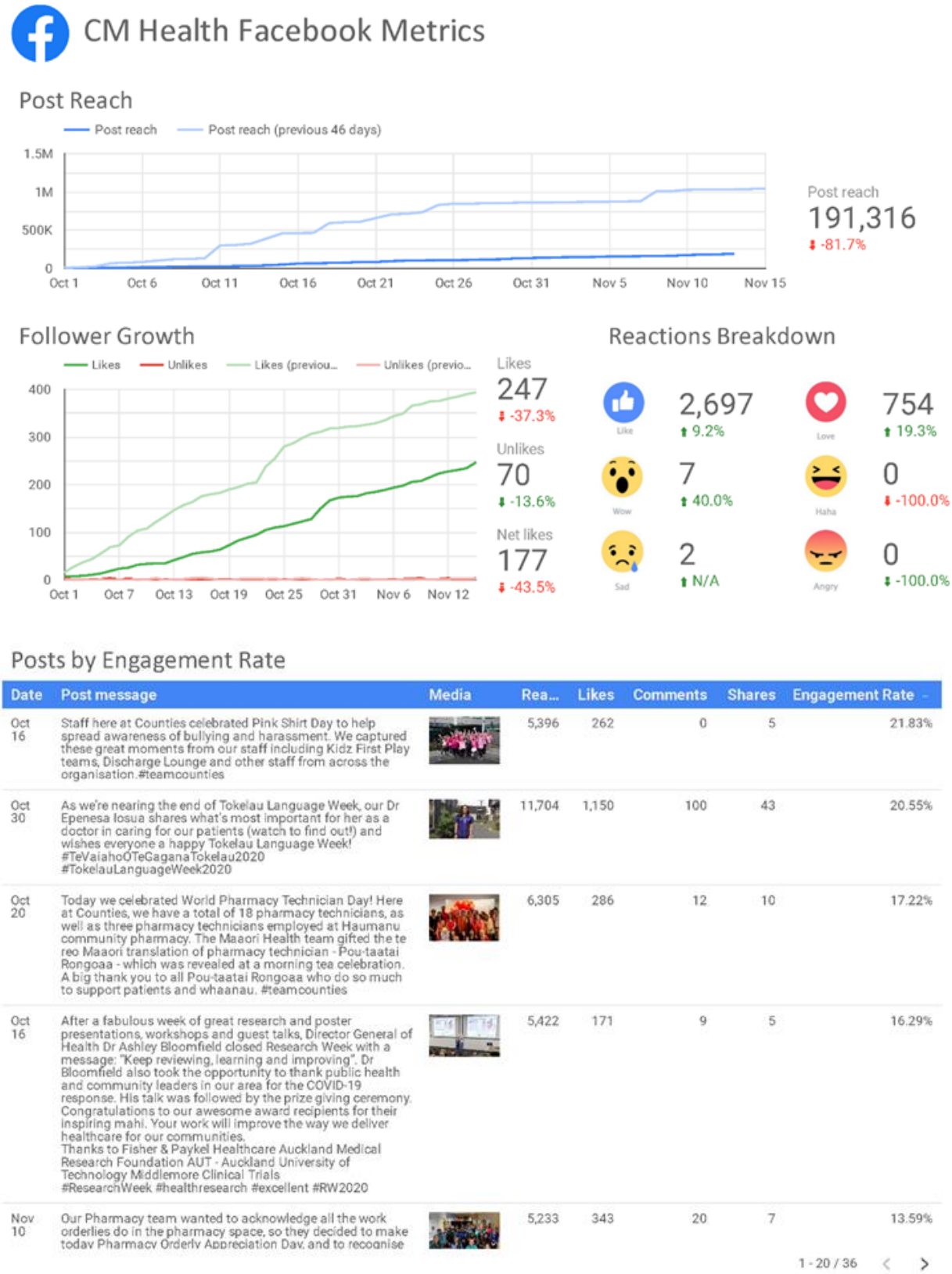

Figure 4 CM Health Facebook metrics and posts

CM Health LinkedIn

A very strong period for LinkedIn with our engagement rate sitting well above the industry average of 2%. In this period, our Research Week post had an engagement rate of 63%, our highest yet.

Post Breakdown

Date	Message	Updat...	Impressions	Likes	Clicks	Comments	Shares	Engagement Rate
Oct 16	After a fabulous week of great research and poster presentations, workshops and guest talks, Director General of Health Dr Ashley Bloomfield closed Research Week with a message: "Keep reviewing, learning and improving". Dr Bloomfield also took the opportunity to thank public health and community leaders in our area for the COVID-19 response. His talk was followed by the prize giving ceremony. Congratulations to our awesome award recipients for their inspiring mahi. Your work will improve the way we deliver healthcare for our communities. Thanks to Fisher & Paykel Healthcare, Auckland Medical Research Foundation, AUT - Auckland University of Technology and Middlemore Clinical Trials. #ResearchWeek #healthresearch #excellent #RW2020		2,971	53	1,833	0	3	63.58
Oct 1	The newly installed windbreaker with its beautiful design by CM Health multimedia designer Corinne Tan, was unveiled this morning by our CEO Fepulea'i Margie Apa. The flowers represent the many cultures of our community framing the entrance of the Manukau SuperClinic. A big congrats to the Manukau Health Park Cultural Advisory Committee and Project team for all their work on the windbreaker. #teamcounties		6,985	166	3,041	9	5	46.11
Oct 20	Today we celebrated World Pharmacy Technician Day! Here at Counties, we have a total of 18 pharmacy technicians, as well as three pharmacy technicians employed at Haumanu community pharmacy. Our Maaori Health team gifted		2,581	49	803	0	0	33.01

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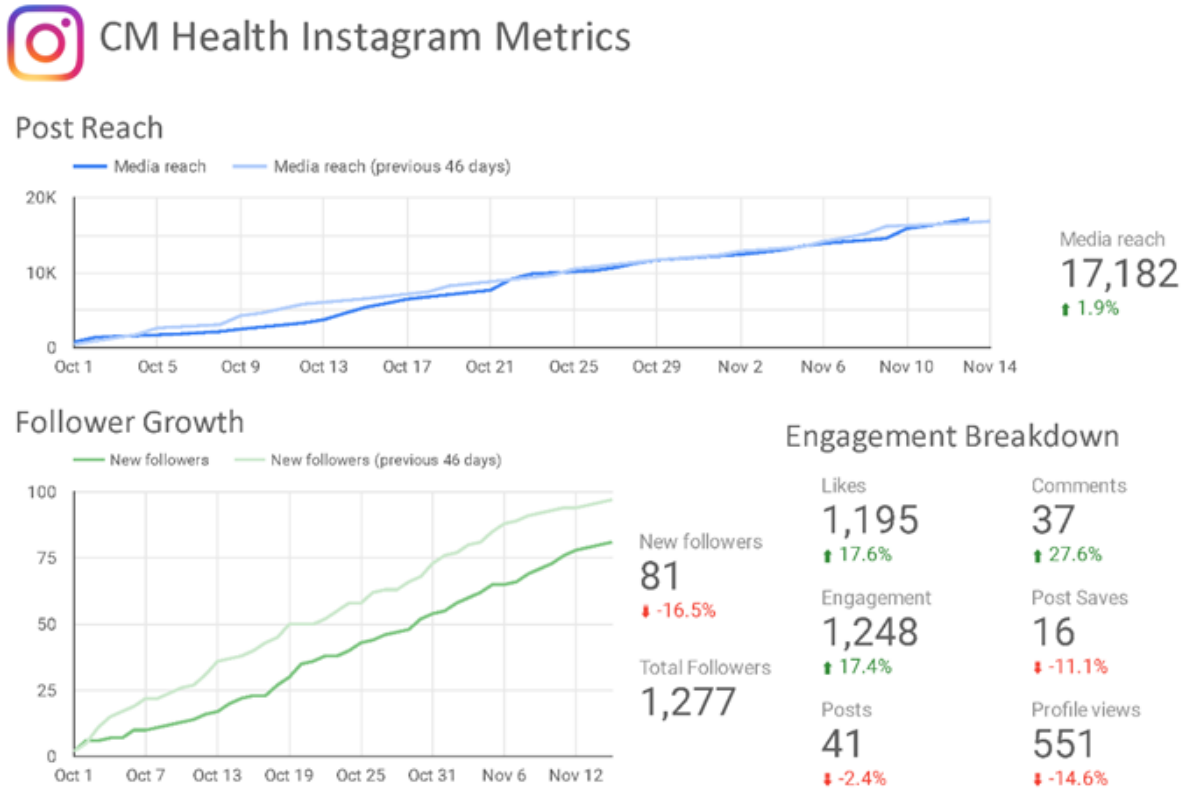
Figure 5 CM Health LinkedIn metrics and posts

CM Health Instagram

We managed a steady period for Instagram as we saw fewer posts during this period. We attempted fewer traditional posts and opted to post some stories, which were seen approximately 3,000 times.



Posts by Engagement Rate

Date	Media caption	Media	Reach	Likes	Commen...	Saves	Engagement Rate
Nov 9	A big congratulations to our Clinical Nurse Director - Medicine Safaato'a Fereti for winning the Pasifika Futures – Pacific Health & Wellbeing Award at the 2020 SunPix Pacific Peoples Awards last week. Much deserved for this amazing waahine! Read more on the awards night here: https://bit.ly/2GMqm8g #teamcounties		657	92	9	1	15.53%
Oct 2	The newly installed windbreaker with its beautiful design by CM Health multimedia designer Corinne Tan, was unveiled this morning by our CEO Fepulea'i Margie Apa. The flowers represent the many cultures of our community framing the entrance of the Manukau SuperClinic. A big congrats to the Manukau Health Park Cultural Advisory Committee and Project team for all their work on the windbreaker. #teamcounties		635	84	4	2	14.17%
Nov 10	Our Pharmacy team wanted to acknowledge all the work orderlies do in the pharmacy space, so they decided to make today Pharmacy Orderly Appreciation Day, and to recognise their work over shared kai. Pharmacy orderlies provide timely supply of medicines to patients. One of our long serving orderlies Jonathan Lambert (15 years of service at Counties; 12 years' service as a pharmacy orderly) said this about what's the most rewarding part of his job: "Getting the medications to the wards at bullet speed!" A big thank you to all the pharmacy orderlies for everything you do for patients and whaanau. #teamcounties		607	72	5	0	12.69%
Oct 17	Staff here at Counties celebrated Pink Shirt Day to help spread awareness of bullying and harassment. We captured these great moments from our staff including Kidz First Play teams, Discharge Lounge and other staff from across the organisation.#teamcounties		567	58	2	0	10.58%
Oct 22	Yesterday we celebrated all the amazing work our Women's Health team have done over the past year at our Women's Health Staff Excellence Awards 2020. It was an opportunity to recognise the exceptional work of some of our Women's		581	58	1	1	10.33%

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Figure 6 CM Health Instagram metrics and posts

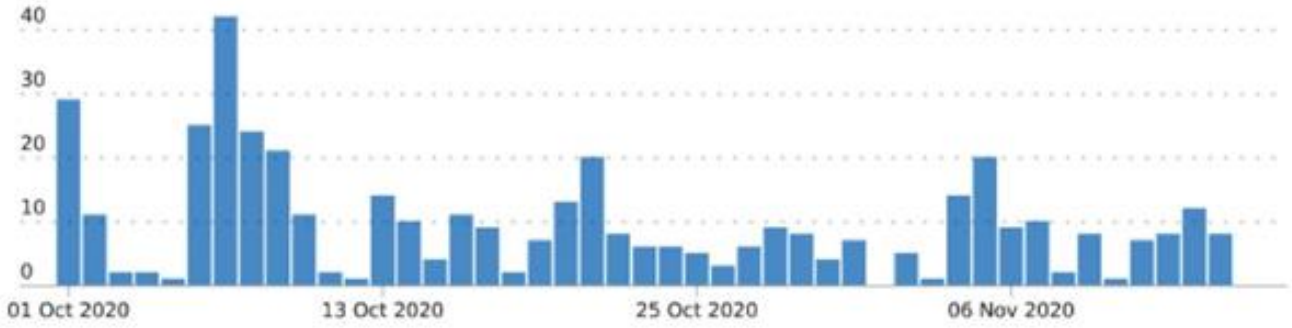
News/Media Listening

Peaks:

- 7 October: Mentions of one person with COVID-19 in Middlemore Hospital
- 21 October: Person dies in house fire plus two others in Middlemore Hospital
- 5 November: Multiple car crash victims in Middlemore Hospital

Contains 428 items within the date range 01/10/2020 - 15/11/2020.

Volume



Sources

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NZ Doctor: 29
Radio New Zealand : 26
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TVNZ: 14
Voxy: 13
Hawke's Bay Today: 10
Newstalk ZB: 10
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Otago Daily Times: 9
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Magic Talk: 7
Times Online: 7
Waikato Times: 7
Whanganui Chronicle: 7
The Press: 6
NZ City: 6
Eastern Courier: 6
Governmentnews.co.nz: 5
Radio New Zealand Audio: 5
Dominion Post: 5
Rotorua Now: 5
Timaru Herald: 4
Indian Weekender: 4
Manawatu Standard: 4
Taranaki Daily News: 4
East & Bays Courier: 4
Police Alerts: 4
Manukau Courier: 3
Franklin County News: 3
Aimee Gulliver: 3
Nelson Mail: 3
Maori Television: 3
Northern Region Health Coordination Centre: 3
Newsroom: 3
MSN: 2
The Devonport Flagstaff: 2
National Business Review: 2
Interest.co.nz: 2
New Zealand Nurses Organisation: 2
The Spinoff: 2
Southland Times: 2
One News Breakfast: 2
Marlborough Express: 1
Hauraki Herald: 1
Manawatu Guardian: 1
E-Tangata: 1
Herald on Sunday: 1
Peter Abernethy : 1
Charlotte Gendall: 1
Western Leader: 1
iStart: 1
Crux: 1
Good Returns: 1
Tagata Pasifika: 1
North Harbour News: 1
Reseller News: 1
Rachael Everitt: 1
Chatswood Consulting: 1
Insurance Business NZ: 1
Sunday News: 1
Waatea News: 1
North Shore Times: 1
Breast Cancer Foundation NZ: 1
Claire Bennett: 1
Shelley Ashdown: 1
NZ Government: 1
New Horizons for Women: 1
Rodney Times: 1
Taupo & Turangi Weekender: 1
HRM Online: 1
Commission for Financial Capability: 1
The AM Show: 1
Sunday Star-Times: 1
Our Auckland: 1
Gay Express: 1

Figure 7 News volume, sources and content type

Information Paper
Counties Manukau District Health Board
Finance and Corporate Business Report

Recommendation

It is recommended that the Board:

Receive this Finance and Corporate Business Report.

Note that this paper presents an overview of the most recent financial result reported to Executive Leadership Team at their meeting on 24 November 2020.

Submitted by: Margaret White – Chief Financial Officer

Glossary

ACC	Accident Compensation Corporation	MMCT	Middlemore Clinical Trials
AUT	Auckland University of Technology	MFAT	Ministry of Foreign Affairs & Trade
CWD	Caseweight Delivery	POAC	Primary Options for Acute Care
DRG	Diagnostic-related Groups	PCT	Pharmaceutical Cancer Treatments
E$C	Every Dollar Counts	PHO	Primary Health Organisation
ED	Emergency Department	SMO	Senior Medical Officer
FPIM	Finance Procurement & Information Mgmt	VLCA	Very Low Cost Access (Primary Care Access)
HOP	Health of Older People	WIES	Weighted Inlier Equivalent Separations
IDF	Inter District Flows	WIP	Work in Progress
MIF	Managed Isolation Facilities	YTD	Year to Date

Purpose

The purpose of this paper is to provide the Board with an overview of the most recent financial result reported to Executive Leadership Team.

1. Key Messages

Financial Result - the underlying variance for the month of October 2020 is $80k unfavourable against budget and $176k unfavourable (YTD).

The full year forecast - There are no material forecast exposures confirmed at the end of October 2020, though we are watching closely E$C Savings performance and IDF exposure. The underlying forecast position at the end of October 2020 is consistent with budget at $29.289m. Further Holidays Act provisions for 2020/21 year and net unfunded COVID costs will be reported as exceptional items.

2020/21 E$C - COVID Wave 2 has significantly disrupted the DHBs savings programme. Services are currently re-activating and a number of projects are gathering momentun. Of the current $17m target however, only $4.87m has been identified as annualised savings for 2020/21. As a consequence, funds are not available for further investment. To date target savings not achieved have been offset by other favourable variances across services, including delays to recruit.

COVID-19 - Calendar year to date CM Health has committed circa $36.9m of cost not yet funded. Processes are now underway to enable and activate funding flows ($15.5m funding has been received for MIF) and compilation of a Q1 wash-up for the 2020/21 period to 30 September. Updates will be provided in due course.

Rolling 5 Year Financial Forecast - Preparatory work is underway to review current five-year financial forecast against 2020/21 operating trends and known outer year commitments. A first draft will be complete mid December to inform 2021/22 planning.

Cash - The DHBs baseline (excl COVID) cash position is expected to dip into overdraft for a few days each month from February 2021. The DHBs cash flow is heavily dependent on timing of capital and unfunded COVID expenditure. This will continue to be monitored closely.

Recognition of contribution – As we come to the end of 2020 I would like to acknowledge the contribution of our extraordinary Finance team. The year has been extremely busy with major capital and pandemic response adding to the demands of a complex system.

Alongside the wider CM Health team, our Finance team has responded with dedication, diligence and kindness. Many have worked extended hours and forgone planned leave to contribute to our Northern Region health response.

All are looking forward to rest and relaxation with friends and family over the coming holiday season.

2. Summary Result and Financial Commentary for the period ended 31 October 2020

The underlying variance for the month of October 2020 is $80k unfavourable against budget and $176k unfavourable (YTD). Adding unbudgeted costs incurred in response to COVID-19 amounting to $323k unfavourable for October 2020 ($2.6m YTD) and provision for ongoing non compliance with the Holiday's Act (pending remediation and rectification) of $5m in the month, which is a YTD catch up ($1.25m per month), the total reported result for the month ended 31 October 2020 is $5.4m unfavourable (YTD $7.79 unfavourable).

Table 1: Summary month and YTD result by division for the period ended 31 October 2020

Reported Net Result	**October 2020**						
	Month			**Year to Date**			**Full Year**
	Act	**Bud**	**Var**	Act	Bud	Var	**Bud**
	$000	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**
Provider	(13,653)	(9,850)	(3,803)	(43,226)	(37,913)	(5,313)	(119,050)
Funder	5,438	7,301	(1,863)	25,913	29,204	(3,291)	95,484

Governance	(223)	(486)	263	(1,284)	(2,094)	810	(5,723)
Reported Net deficit	(8,436)	(3,035)	(5,403)	(18,597)	(10,802)	(7,794)	**(29,289)**
COVID-19 costs not funded	(323)	-	(323)	(2,618)	-	(2,618)	-
Holidays Act remediation impact	(5,000)	-	(5,000)	(5,000)	-	(5,000)	-
Underlying result	**(3,115)**	**(3,035)**	**(80)**	**(10,979)**	**(10,802)**	**(176)**	**(29,289)**

Commentary on DHB Consolidated Financial Performance (reported net deficit)

Provider Update - The Provider Arm produced a $3.8m unfavourable result against budget for the month of October 2020, (YTD $5.3m unfavourable).

Favourable variances:
- Net unbudgeted COVID-19 upside mainly in relation to the Managed Isolation Facilities funding recognised in arrears;
- Vacancies across the system in difficult to recruit to positions; and
- Financing costs, in particular a lower Capital Charge provision as a result of a higher Deficit result for the year ended 2019/20.

Offset by unfavourable variances:
- Locum cover for Medical vacancies current vacancies in Mental Health 8.9FTE, general medicine 5.3FTE and Anaesthesia and Pain 8.8FTE;
- Increased cover for patient watches; and
- Unrealised target savings due to redeployment of project team members to support tactical COVID-19 project priorities, the majority of the E$C portfolio has been paused, and is due to be re-evaluated.

There were 9,361 ED presentations in Oct-20 compared to 9,609 same time last year. The reduced presentations have contributed to an underspend in ED but due to the increased acuity of patients presenting, the percentage of patients being admitted has increased. In Oct-20, 34 % of the ED admissions were admitted compared to 32% in Sep-19. As a result of this, the hospital has been running with high bed occupancies.

Funder Update - Funder Arm's produced a $1.8m unfavourable result against budget for the month of October 2020, (YTD $3.29m unfavourable).

Favourable variances:
- Mental Health initiative investment delays resulting in underspend;
- Unbudgeted close out of 19/20 POAC provision no longer required.

Offset by unfavourable variances;
- IDF wash up provision accrual mainly due to our under delivery of Inflow volumes versus contract; and
- Covid-19 costs not yet funded (the main driver for the overall Funder variance).

Governance - $263k favourable (YTD $810k favourable). The YTD favourable is primarily due to vacancies in the Governance & Funding division and timing differences in planned expenditure.

The full Statement of Financial Performance is presented in the below (Table 2).

Table 2: Consolidated reported and underlying result (Month and Cumulative YTD)

CMDHB October 2020	Month Variance									YTD Variance								FY Bud
Statement of Financial Performance	**Month (BAU)**			**Savings**	**Underlying Variance**	**Holidays Act**	**COVID**	**Planned Care & Waitlist**	**Reported Variance**	**YTD (BAU)**			**Savings**	**Underlying Variance**	**Holidays Act**	**COVID**	**Planned Care & Waitlist**	**Reported Variance**	**Full Year**
	Actual $(000)	Budget $(000)	Variance $(000)	Variance $(000)	Variance $(000)	Variance $(000)	Variance $(000)	Variance $(000)	Variance $(000)	Actual $(000)	Budget $(000)	Variance $(000)	Variance $(000)	Variance $(000)	Variance $(000)	Variance $(000)	Variance $(000)	Variance $(000)	**Budget** $(000)
Revenue																			
Government Revenue	162,513	158,631	3,882	(17)	3,865		6,410	(315)	9,960	651,924	634,675	17,250	(68)	17,181		32,609	(1,261)	48,530	1,903,655
Patient/Consumer Sourced	864	1,035	(171)	(32)	(203)		0		(203)	3,347	4,140	(793)	(127)	(920)		0		(920)	12,802
Other Income	2,783	2,536	247	(73)	174		1,082		1,255	9,535	10,207	(672)	(292)	(964)		1,138		174	31,292
Total Revenue	166,160	162,202	3,957	(122)	3,836	0	7,492	(315)	11,013	664,806	649,022	15,784	(487)	15,297	0	33,748	(1,261)	47,784	1,947,749
Medical	20,039	20,580	541	(275)	266	(1,599)	204		(1,129)	81,330	82,107	776	(1,101)	(325)	(1,599)	(184)		(2,107)	239,814
Nursing	25,739	24,792	(947)	(382)	(1,330)	(1,924)	(1,122)		(4,376)	97,092	97,814	722	(1,529)	(807)	(1,924)	(2,742)		(5,473)	288,907
Allied	8,281	8,721	439	(129)	310	(639)	(253)		(582)	32,989	34,743	1,754	(516)	1,238	(639)	(901)		(302)	102,352
Support	3,373	3,440	67	(96)	(29)	(229)	(249)		(508)	13,306	13,475	169	(386)	(217)	(229)	(623)		(1,069)	39,458
Management and Admin	7,596	7,981	386	(119)	266	(609)	(519)		(861)	30,591	32,530	1,939	(477)	1,462	(609)	(1,618)		(765)	93,058
Total Personnel	65,028	65,513	486	(1,002)	(517)	(5,000)	(1,939)	0	(7,456)	255,309	260,669	5,360	(4,010)	1,351	(5,000)	(6,067)	0	(9,717)	763,590
Outsourced Personnel																			
Medical	976	462	(514)	0	(514)		(315)		(829)	4,052	1,863	(2,189)	0	(2,189)		(584)		(2,773)	5,530
Nursing	312	41	(271)	0	(271)		(14)		(285)	1,187	165	(1,023)	0	(1,023)		(141)		(1,164)	485
Allied Health	78	19	(58)	0	(58)		(27)		(85)	318	80	(239)	0	(239)		(27)		(266)	232
Support	93	0	(93)	0	(93)		0		(93)	492	0	(492)	0	(492)		0		(492)	0
Management and Admin	529	250	(280)	0	(280)		(54)		(333)	1,941	1,000	(941)	0	(941)		(144)		(1,085)	2,999
Total Outsourced Personnel	1,988	772	(1,216)	0	(1,216)	0	(410)	0	(1,626)	7,991	3,107	(4,884)	0	(4,884)	0	(896)	0	(5,780)	9,246
Outsourced Clinical Services	2,729	2,982	253	(89)	164		(165)	315	313	11,213	11,966	753	(356)	397		(5,580)	1,261	(3,922)	34,694
Outsourced Corporate Services	4,363	4,495	132	(33)	99		(119)		(20)	17,347	17,979	632	(133)	499		(221)		278	53,537
Clinical Supplies	11,698	11,409	(288)	(122)	(411)		(944)		(1,354)	46,233	45,842	(391)	(489)	(880)		(1,845)		(2,725)	133,616
Infrastructure	6,388	7,480	1,092	(120)	972		(1,455)		(483)	26,749	29,918	3,169	(479)	2,690		(4,543)		(1,854)	88,132
Provider Payments	71,628	68,420	(3,208)	0	(3,208)		(2,782)		(5,990)	289,319	273,680	(15,640)	0	(15,640)		(17,213)		(32,852)	821,368
Total Other Direct Costs	98,794	95,558	(3,236)	(364)	(3,600)	0	(5,875)	315	(9,161)	398,852	382,491	(16,361)	(1,457)	(17,818)	0	(30,298)	1,261	(46,855)	1,140,592
Total Operating Surplus/(Deficit)	**2,338**	**1,131**	**1,207**	**(1,488)**	**(282)**	**(5,000)**	**(323)**	**0**	**(5,604)**	**10,646**	**5,862**	**4,784**	**(5,954)**	**(1,170)**	**(5,000)**	**(2,618)**	**0**	**(8,788)**	43,567
Depreciation	3,293	3,405	112	0	112		0		112	13,148	13,620	472	0	472		0		472	40,861
Interest	6	6	0	0	0		0		0	24	24	0	0	0		0		0	72
Capital Charge	2,619	2,709	90	0	90		0		90	10,315	10,837	523	0	523		0		523	32,512
Total Finance Costs	5,919	6,120	202	0	202	0	0	0	202	23,487	24,482	995	0	995	0	0	0	995	73,445
Net Surplus/(Deficit)	**(3,581)**	**(4,989)**	**1,409**	**(1,488)**	**(80)**	**(5,000)**	**(323)**	**0**	**(5,403)**	**(12,842)**	**(18,620)**	**5,778**	**(5,954)**	**(176)**	**(5,000)**	**(2,618)**	**0**	**(7,793)**	**(29,878)**

Commentary on Major Variances in relation to the underlying result (>$500k)

Major variances in the underlying result (excluding unbudgeted COVID, Holidays Act and Planned Care) are explained for the month and YTD below.

Month

Government Revenue $3.8m - The majority of the underlying variance is from additional funding matched by additional costs, as follows:

	Month
PHO IDF wash up	$1.4m
Pharmacy funding	$0.4m
PHO – VLCA/Careplus/U14's	$0.8m
Primary Care Mental Health	$0.6m
	$3.2m

Nursing personnel $(1.33m) unfavourable - reflecting unrealised savings of $(382)k and increased Nursing Care Partners $(290)k, COVID AL provision reduction $(387)k, costs for resourcing additional cots in Neonatal Unit $(434)k offset by vacancy savings in harder to recruit areas.

Outsourced Medical $(514k) unfavourable - Locum Medical staff to cover SMO vacancies in Psychiatry, General Medicine and Ophthalmology.

Infrastructure $972k - reduced bad debt provision $940k.

Provider Payments $(3.2m) unfavourable - The majority of the underlying variance is matched by additional funding, as follows:

	Month
PHO IDF wash up	$1.4m
Pharmacy funding	$0.4m
PHO – VLCA/Careplus/U14's	$0.8m
Primary Care Mental Health	$0.6m
	$3.2m

Other variances that have an impact on the net result are as follows:

	Impact	Month
IDF wash up provision accrual	Unfavourable	$0.9m
Mental Health NGO underspend	Favourable	$0.3m
POAC provision release	Favourable	$0.3m
HOP underspend including Pay equity	Favourable	$0.1m
Long Term Support – Chronic Health	Favourable	$0.1m
	Net Unfavorable	**$0.1m**

Year To Date

Government Revenue $17.2m - The majority of the underlying variance is from additional funding matched by additional costs, as follows:

	YTD
PHO IDF wash up	$5.8m
Pharmacy funding	$1.7m
PHO – VLCA/Careplus/U14's	$5.5m
Primary Care Mental Health	$2.2m
	$15.2m

Additional ACC revenue ahead of contract $479k, CTA programme ahead of plan $328k (offset by cost).

Patient/consumer revenue $(920k) unfavourable - This mostly due to unrealised savings $(120)k, Tahitian burns of $(700)k unfavourable to budget as a result of lost revenue due to COVID travel restrictions (partly offset by cost) and a lower level of residential care patient co-payments (lower number of patients) $(274)k.

Other Income $(964k) unfavourable - Unrealised savings $(292)k, COVID-19 impact on Pacific revenue $(629)k due to travel restrictions eg NZ Medical Treatment Scheme with MFAT (direct impact on revenue and cost) and donations lower than expected $(331)k, these are offset by unbudgeted revenue MMCT and AUT $254k.

Nursing personnel $(807k) unfavourable - The YTD variance is mainly due to unrealised savings ($1.5)m, overtime to cover vacancies & roster gaps and increased patient watches, offset by vacancies savings.

Allied Personnel $1.2m - This underspend is due to vacancy and skill mix changes $1.9m offset by unrealised savings $(516)k and lower uptake of annual leave $(251)k.

Man/Admin Personnel $1.5m - The favorable is mostly due to vacancy savings and a one off YTD adjustment of $688k transferring Annual Leave costs to COVID-19 (net annual leave accrued vs taken is lower when compared to the same time last year due to COVID-19) offsetting unrealised savings $(477)k.

O/S Medical $(2.2m) - Locum Medical staff to cover SMO vacancies in Psychiatry $(1.5)m and General Medicine $(241)k and Ophthalmology $(277)k.

O/S Nursing $(1.0m) unfavourbale - This variance is due to the use of the external agencies to cover roster gaps, vacancies and care partners.

Clinical Supplies $(880k) unfavourbale - Unrealised E$C savings $(489)k and additional costs incurred in the over delivery of Planned Care & waitlist reduction $(655)k offset by underspends in Pharmaceutical Cancer Treatments (PCT's) through access to cheaper generic brands and delayed implementation of Toto Ora.

Infrastructure $2.7m - Unrealised E$C savings $(479)k offset by capitalization of capital projects $972k offset in outsourced admin costs, reduction in bad debt provision $940k and underspends in Travel, outsourced Facilities maintenance and cleaning & laundry.

Provider payments $(15.7m) unfavourable - The majority of the underlying variance is matched by additional funding, as follows:

	YTD
PHO IDF wash up	$5.8m
Pharmacy funding	$1.7m
PHO – VLCA/Careplus/U14's	$5.5m
Primary Care Mental Health	$2.2m
	$15.2m

Other variances that have an impact on the net result are as follows:

	Impact	YTD
IDF wash up provision accrual	Unfavourable	$4.1m
Mental Health NGO underspend	Favourable	$1.3m
POAC provision release	Favourable	$0.5m
HOP underspend including Pay equity	Favourable	$1.0m
Long Term Support – Chronic Health	Favourable	$0.4m
	Net Unfavorable	**$0.9m**

Planned Care - The YTD revenue reflects compensation for the actual level of outsourced activity for Planned Care.

In October, a revenue adjustment of $550k was advanced to compensate for the over delivery of Planned Care volumes by 99 CWD (1.5%).

The Statement of Financial Position and Statement of Cash Flows are presented in Appendix 1 and 2 of this report.

3. Cash Forecast

Cash balance as at 31 October 2020 was $14.6m. This balance includes $14.1m remaining proceeds from the sale of land (these proceeds will partially fund the Cath Lab and Gastro projects). Thus the operating cash balance is circa $500k.

CM Health Finance continues to monitor and focus its operational and capital cash flow spend and forecasting to comply with the expectations set by the Minister of Health and the Director General of Health. The cash flow fluctuations are largely dependent on supplier payments, timing of capital spend which can vary month to month and more recently the unpredictable cash flow requirements in relation to COVID-19.

Cash forecasts have been updated to reflect the 2020/21 Board approved budget. The impact of COVID costs not funded by the MOH will be better understood following the 2020/21 COVID Q1 wash-up currently in process. Updates will be provided in due course.

Appendix 1: Statement of Financial Position as at 31 October 2020

Table 3: Statement of Financial Position as at 31 October 2020

	Act $ 000	Budget $ 000	Var $ 000	Sep-20 $ 000	Movement $ 000
Current Assets					
Petty Cash	8	8	-	8	-
Bank	14,605	27,147	(12,542)	15,736	(1,131)
Trust	837	837	-	837	-
Prepayments	5,772	2,877	2,895	5,311	461
Debtors	68,744	61,114	7,630	82,136	(13,392)
Inventory	11,264	11,305	(41)	10,981	283
Assets Held for Sale	5,320	5,320	-	5,320	-
Total current Assets	**106,550**	**108,608**	**(2,058)**	**120,329**	**(13,779)**
Fixed Assets					
Land	193,430	193,430	-	193,430	-
Buildings, Plant & Equip	696,759	699,444	(2,685)	695,194	1,565
Information Technology	2,682	3,045	(363)	2,682	-
Information Software	2,165	2,245	(80)	2,165	-
Motor Vehicles	1,472	1,472	-	1,472	-
Total Cost	**896,508**	**899,636**	**(3,128)**	**894,943**	1,565
Accum. Depreciation	(106,215)	(103,404)	(2,811)	(102,951)	(3,264)
Net Cost	**790,293**	**796,232**	**(5,939)**	**791,992**	**(1,699)**
Work In-progress	75,844	71,565	4,279	72,207	3,637
Total Fixed Assets	**866,137**	**867,797**	**(1,660)**	**864,199**	**1,938**
Reversionary car park interest	2,050	2,050	-	2,050	-
Investments in Associates	55,563	55,989	(426)	55,593	(30)
Total Assets	**1,030,300**	**1,034,444**	**(4,144)**	**1,042,171**	**(11,871)**
Current Liabilities					
Creditors	122,049	126,776	(4,727)	137,612	(15,563)
Income in Advance	30,554	24,535	6,019	28,173	2,381
GST and PAYE	19,896	18,674	1,222	19,271	625
Payroll Accrual & Clearing	27,759	30,272	(2,513)	24,466	3,293
Employee Provisions	287,965	279,621	8,344	282,137	5,828
Total Current Liabilities	**488,223**	**479,878**	**8,345**	**491,659**	**(3,436)**
Working Capital	(381,673)	(371,270)	(10,403)	(371,330)	(10,343)

Net Funds Employed	**542,077**	**554,566**	**(12,489)**	**550,512**	**(8,435)**
Non-Current Liabilities					
Employee Provisions	37,267	37,267	-	37,267	-
Trust and Special Funds	837	837	-	837	-
Insurance Liability	990	990	-	990	-
Total Non-Current Liabilities	**39,094**	**39,094**	**-**	**39,094**	**-**
Crown Equity					
Crown Equity	444,491	446,155	(1,664)	444,493	(2)
Revaluation Reserve	393,379	393,379	-	393,379	-
Retained Earnings	(334,887)	(324,062)	(10,825)	(326,454)	(8,433)
Total Crown Equity	**502,983**	**515,472**	**(12,489)**	**511,418**	**(8,435)**
Net Funds Employed	**542,077**	**554,566**	**(12,489)**	**550,512**	**(8,435)**

Commentary on Major Variances:

- Closing bank was $12.5m unfavourable to budget in October 2020. Net cash flows from operations YTD (revenue, expenses and payroll) was $12.9m unfavourable to budget (refer cash flow variance explanation for further details).
- Prepayments were $2.9m higher than Budget primarily due to the prepayments of insurance and Objective Software licences paid at the beginning of the year, plus FPIM investment assets classified as a prepayment.
- Debtors were $7.6m higher than Budget largely due to COVID-19 related MoH invoices and a reduction in Bad Debts provision.
- Net fixed assets are less than Budget by $4.1m due to the timing of capital spend and asset capitalisations.
- Creditors are $4.7m less than Budget due to timing of invoices and accruals (including COVID related).
- Income In Advance was higher than Budget by $6m largely due to COVID-19 funding advances and timing of revenue recognised in the month.
- Employee provisions are higher than Budget due largely to an unbudgeted accrual for Holidays Act remediation of $5m.

Appendix 2: Statement of Cash Flows for the period ended 31 October 2020

Table 4: Statement of Cash flow for the period ended 31 October 2020

	Month			YTD		
	Act	**Budget**	**Var**	**Act**	**Budget**	**Var**
	$ 000	**$ 000**	**$ 000**	**$ 000**	**$ 000**	**$ 000**
Cash flows from Operating activities						
Cash was provided from:						
Crown Revenue	168,249	147,069	21,180	629,202	588,383	40,819
Other	21,132	15,171	5,961	67,562	60,790	6,772
Cash was applied to:						
Suppliers	(124,984)	(95,200)	(29,784)	(438,612)	(381,059)	(57,553)
Employees	(62,380)	(63,378)	998	(256,679)	(252,126)	(4,553)
Goods and services tax (net)	2,008	-	2,008	1,573	-	1,573
Capital charge	-	-	-	(1)	-	(1)
Net cash from Operations	**4,025**	**3,663**	**362**	**3,045**	**15,987**	**(12,942)**
Cash flows from Investing activities						
Cash was applied to:						
Fixed assets	(5,201)	(5,156)	(45)	(17,275)	(21,272)	3,997
Investments	-	(102)	102	-	(408)	408
Interest received	45	83	(38)	180	333	(153)
Restricted & Trust Funds	-	-	-	-	-	-
Net cash from Investing	**(5,156)**	**(5,175)**	**19**	**(17,095)**	**(21,347)**	**4,252**
Cash flows from Financing activities						
Cash was provided from:						
Sale of Asset	-	1	(1)	-	3	(3)
Other equity movement	-	-	-	1	-	1
Equity injection	-	4,013	(4,013)	2,334	8,685	(6,351)
Net cash from Financing	-	4,014	(4,014)	2,335	8,688	(6,353)
Net increase / (decrease)	**(1,131)**	**2,502**	**(3,633)**	**(11,715)**	**3,329**	**(15,044)**
Opening cash	16,581	27,992	(11,411)	27,165	27,165	-
Closing cash	**15,450**	**30,494**	**(15,044)**	**15,450**	**30,494**	**(15,044)**

Reconciliation Summary

Net Surplus/(Deficit)	**(8,435)**	**(3,034)**	**(5,401)**	**(18,591)**	**(10,800)**	**(7,791)**
Add/(Less) non-cash items						
Impairment of Intangibles	-	-	-	-	-	-
Depn and Amortisation of assets	3,293	3,405	(112)	13,148	13,620	(472)
	(5,142)	371	(5,513)	(5,443)	2,821	(8,264)
Add/(Less) items Classified as Investing or Financing activities						
Interest received	(45)	(83)	38	(180)	(333)	153
Write off of Work-in-Progress	-	-	-	-	-	-
Gain/(loss) on Disposal	-	(1)	1	-	(3)	3
Add/(Less) Movements in Financial Position items						
Debtors and Other Receivables	12,931	2,709	10,222	(10,525)	10,837	(21,362)
Inventories	(283)	-	(283)	41	-	41
Creditors	(23,001)	667	(23,668)	12,561	2,666	9,895
Employee Entitlements	19,565	-	19,565	6,591	-	6,591
	9,212	3,376	5,836	8,668	13,504	(4,836)
Net Cash flow from Operations	**4,025**	**3,663**	**362**	**3,045**	**15,988**	**(12,943)**

Commentary on Major Variances for the year:

- Revenue from the Crown and other revenue were $47.6m favourable to budget YTD mainly due PHO practice revenue variances (offset by additional expenditure) and COVID-19 funding (partially offset by additional expenditure).
- Payments to suppliers for YTD October were $57.6m higher than budget mainly as a result of variations to the planned timing of supplier payments, provider payments and COVID-19 payments.
- Payments to employees for YTD October were $4.5m over Budget mainly as a result of planned timing of payments in the budget.
- Fixed Assets $4.3m YTD favourable to budget representing the delayed timing of capital spend for major capital projects.
- The equity injection is below Budget by $6.4m mainly as a result of underspend for the Acute Mental Health Unit project Stage 2, resulting in the last quarterly equity injection drawdown not being required and less draw-downs of other major projects.

Information Paper
Counties Manukau District Health Board
Smokefree Policy and Designated Vaping Area

Recommendation

It is recommended that Board:

Receive this paper which outlines changes to the CM Health Smokefree Policy and a designated vaping area at Tiaho Mai.

Note the plans outlined in this paper were approved by the Executive Leadership Team on 29 September 2020 and presented to the Hospital Advisory Committee meeting on 4 November 2020 and requested to go forward to the Board for information.

Prepared and submitted by: Basil Fernandes (Portfolio Manager, Smokefree) and Sarah Sharpe (Public Health Physician, Population Health) on behalf of Gary Jackson (Director, Population Health).

Glossary

CMDHB – Counties Manukau District Health Board
CM Health – Counties Manukau Health
CPHAC – Community and Public Health Advisory Committee
ELT – Executive Leadership Team
HAC – Hospital Advisory Committee
HDU - High Dependency Unit
LDU - Low Dependency Unit
VA – Vaping Area

Purpose

The purpose of this paper is to present the updated Smokefree Policy and a plan for a designated vaping area outside at Tiaho Mai, as previously discussed, supported and requested at the CPHAC meeting on 1 July 2020, approved by ELT on 29 September 2020, and presented at the HAC on 4 November 2020.

Executive Summary

This paper presents the updated CMDHB Smokefree Policy (see Appendix 1) and a planned location for a designated vaping area outside at Tiaho Mai (see diagram and photos in this paper). The rationale for having a vaping area is to be able to support mental health inpatients in their smokefree journeys by enabling them to access a dedicated, discreet, comfortable, and smokefree place where they can use vaping products if they would like to.

It has been requested by HAC that this paper is brought to the Board for further discussion. This plan, and updated Smokefree Policy, is brought in the context of a) implementation by the Government of the updated legislative framework covering tobacco and vaping products[1] (see Appendix 2 for powerpoint summary), b) guidance from the Ministry of Health supporting the use of vaping as a smoking cessation

[1] Smokefree Environments and Regulated Products (Vaping) Amendment Bill: https://www.parliament.nz/en/pb/bills-and-laws/bills-proposed-laws/document/BILL_94933/smokefree-environments-and-regulated-products-vaping

tool and as an opportunity to reduce smoking prevalence rates and inequities,[2] and c) three key public health principles related to vaping products i.e.:

1. Vaping is less harmful than smoking. People who smoke currently should be provided the option of using vaping products as one of the possible stop-smoking tools, with the aim to stop vaping completely when there is no risk of relapse.
2. Vaping is not harmless and people who don't smoke should not be using these products. There is a need to protect people who don't smoke, particularly minors and youth, from vaping and becoming nicotine dependent.
3. The safety and long-term health impacts of vaping are currently unclear as the evidence is still emerging; a precautionary approach should be utilised.

Background

An update on the Smokefree Environments and Regulated Products (Vaping) Amendment Act is provided (Appendix 2). The Bill was introduced to Parliament on 24 February 2020, had its first reading on 11 March 2020, was considered by the Health Select Committee with final report published 02 June 2020, had its third reading on 04 August 2020 and passed into law. The Act commenced on 11th Nov 2020 and will be phased in over a 15-month period.

The Smokefree Environments and Regulated Products (Vaping) Amendment Bill amended the Smokefree Environments Act 1990 to bring the provisions of the Act up to date and to ensure that all regulated products (i.e. tobacco smoking products, herbal smoking products, smokeless tobacco products, and vaping products) are covered by the regulatory framework. The Act strikes a balance by supporting vaping as a smoking cessation tool while also preventing the normalisation of vaping and protecting people who don't smoke, particularly children and young people, from the harms of vaping.

Changes include:
- prohibiting vaping in legislated smokefree areas,
- prohibiting advertising, endorsements and sponsorship of vaping products (with some exemptions),
- prohibiting the sale and supply of regulated products to people under the age of 18,
- allowing for approved vaping premises, and
- restricting vape flavours, and introducing product notification and safety rules.

In order to support people to quit smoking, smoking cessation services are exempt from the prohibitions within the Act. For example, publicly-funded smoking cessation services can supply free or discounted flavoured vaping products as part of a stop-smoking programme, either directly or via a Specialist Vape Retailer.

Plan

Planned changes to the CM Health Smokefree Policy are as follows (see Appendix 1 for the entire policy with track changes).

CM Health policy current wording (page 2): "*E- Cigarettes are not to be used on Counties Manukau Health premises in line with Ministry of Health Advice On E- Cigarettes".*

Revised wording:
"Counties Manukau Health seeks to balance the objectives of 1) supporting people who smoke who choose to vape for smoking cessation or harm reduction and 2) protecting people, particularly children and young people, from risks associated with vaping.

[2] Ministry of Health position statement on vaping: https://www.health.govt.nz/our-work/preventative-health-wellness/tobacco-control/vaping-and-smokeless-tobacco

People who choose to vape to quit smoking may do so only in designated outside areas within the Counties Manukau Health grounds. This includes e-cigarettes (vapes) and other products that are not smoked (e.g. 'heat not burn' products).
Advice and support regarding the use of vaping products for smoking cessation and harm reduction is available from the Living Smokefree Service."

Designated Vaping Area

In consultation with the Tiaho Mai leadership team, we have arranged an appropriate location for a designated vaping area to be trialed during the summer months of 2020/21. We have planned for the designated vaping area be located in a discreet place within the fenced grounds of Taiho Mai. The vaping area will only be for use by Tiaho Mai patients from the Low Dependency Unit (LDU). A separate vaping area will be made available to Tiaho Mai patients from the High Dependency Unit (HDU) through a planned research study "Feasibility, acceptability and impact on agitation and aggression of providing nicotine vaporisers in a closed Adult Mental Health Service unit - The eCIMUS study (Use of electronic Cigarettes in Inpatient Mental health service users who Smoke)".[3] No other vaping areas in the hospital grounds will be available at this stage, however if this test goes well, we could look to introduce a further vaping area for non-mental health in-patients.

Map and Photos of Location of Planned Tiaho Mai Vaping Area

- The diagram below shows a map of Tiaho Mai with the boundary fence location indicated by the black dashed line.
- An area designated for vaping is planned to be located close to the boundary fence ('VA' in red). The area will have two bench seats and umbrellas for shelter costing approximately $1500.
- Number 1 (in red) on the map indicates the position where the photos (see below) have been taken from.

Figure 1. Map of Tiaho Mai

[3] This study is a collaboration between CMDHB and University of Auckland (Principal Investigators: Professor Chris Bullen, University of Auckland; Dr Coni Kalinowski, CM Health).

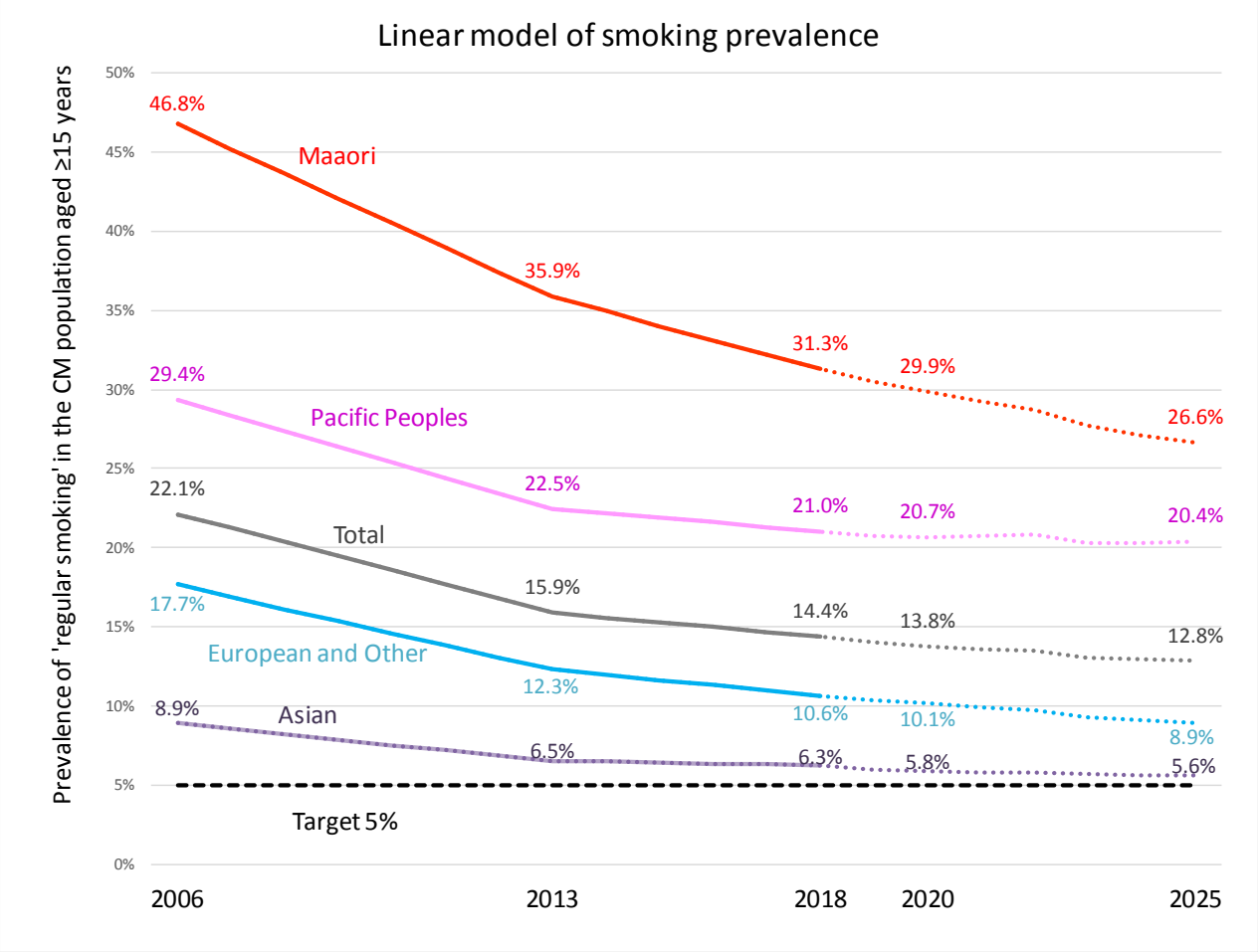
Figure 2. Photo 1 & 2 (taken from Te Manawa Vegetable Garden)

Equity

Smoking is one of the most significant preventable risk factors for premature death and morbidity in New Zealand.[4] It is a key driver of inequities in health outcomes for Maaori and Pacific Peoples in Counties Manukau. Large contributions to the life expectancy gap in CM (8 years and 7 years between Maaori and Pacific Peoples, respectively, and New Zealand European/Other) are from the potentially preventable long-term health conditions cardiovascular disease, diabetes, respiratory disease and cancers.[5] Smoking cessation (alongside reducing obesity, poor nutrition, and alcohol use, and improving physical activity) is critically important for prevention of these diseases and reducing the life expectancy gap, as well as other important conditions and inequities (e.g. pregnancy outcomes, infant and child health).

It is estimated that, in 2020, approximately 61,000 CM Health residents smoke regularly, 30% of whom are Maaori and 30% Pacific people. Although smoking prevalence is reducing, stark ethnic inequities remain, and current actions are not enough to achieve the Smokefree 2025 goal (5% or less smoking prevalence across all groups), as shown in the following chart.

Figure 3. Smoking prevalence in the CM population



'Regular smoking' prevalence in adults, Census 2006, 2013 and 2018, with linear extrapolation to 2025 based on the change between 2013 and 2018, and using prioritised ethnicity

The use of vaping products by people who smoke provides an opportunity to dramatically reduce smoking prevalence rates and reduce inequities. The CM Health Living Smokefree Service, which is among the highest performing smoking cessation services in the country with quit rates at 4 weeks (verified by carbon monoxide levels in breath) of 79% overall, is a 'vape-friendly' service with staff who have expertise in

[4] Institute for Health Metrics and Evaluation. GBD Compare, 2017. Available from: https://vizhub.healthdata.org/gbd-compare/

[5] Chan WC, Papa D, Winnard D (2019). Life Expectancy in Counties Manukau. 2018 update. Auckland: Counties Manukau Health.

supporting clients who choose to vape to quit. Service data show high and equitable quit rates among people who use vaping to help them quit.

Smoking prevalence among mental health inpatients is very high. Clinical audit for March and April 2020, carried out by Tiaho Mai staff, showed that 82% of people admitted to Tiaho Mai during March and April were people who smoke.

Appendices

1. CM Health Smokefree Policy *(attached separately)*
2. Update on the Smokefree Environments and Regulated Products (Vaping) Amendment Act *(attached separately)*

Policy: Smokefree

Purpose

The purpose of this policy is to outline Counties Manukau Health's expectations regarding:

- The health and safety of all individuals within Counties Manukau Health premises and environments;
- Compliance with the Smokefree Environments and Regulated Products (Vaping) Amendment Act 2020~~Smoke-free Environments Act 1990 and Amendments 2003~~ and the Health & Safety in Employment Act (HSEA) 1992 and Amendments 2002; and
- Reduction in smoking rates among staff and the community, in accordance with the New Zealand Government goal for a Smokefree Aotearoa 2025 and Counties Manukau Health's commitment to a Smokefree Counties Manukau by 2025.

Counties Manukau Health is required to ensure that no person smokes at any time in the workplace. As part of its wider role in promoting health and wellbeing, Counties Manukau Health has a responsibility to encourage and support patients and staff not to smoke.

Scope

This policy is applicable to all Counties Manukau Health employees, patients and whaanau, visitors, volunteers, contractors and all others accessing Counties Manukau Health grounds and facilities. It applies to all buildings, grounds and vehicles owned or occupied by Counties Manukau Health, including business and social venues.

Policy

Counties Manukau Health buildings, sites, grounds, offices and vehicles are completely smokefree. Staff cannot smoke on site or where services to patients are being provided off-site (e.g. home visits, community based clinics) or wherever staff are representing Counties Manukau Health.

Smokefree Environment

All Counties Manukau Health sites are smokefree. No smoking or vaping is permitted by anyone **inside** Counties Manukau Health buildings, vehicles and offices, including in any buildings leased by Counties Manukau Health.

Staff, patients and whaanau, and visitors may NOT smoke in **external** areas on any site owned by Counties Manukau Health or controlled by them under a lease arrangement.

They must leave the site if they wish to smoke. On-site includes boundary fences, gardens and entrances to sites.

At the point of employment and during orientation, staff will be informed of the smokefree policy and support programmes offered to assist staff who smoke. Staff who wish to smoke off-site should not be identifiable as Counties Manukau Health staff by their uniforms or name tags, or any other form of identification.

Tobacco Products

NO tobacco products may be sold on any Counties Manukau Health premises. No staff member or volunteer will accept gifts or donations of tobacco products from organisations or charities. Staff may not purchase tobacco products on behalf of patients or supply tobacco products including oral tobacco, to patients.

Supporting People Who Smoke Who Choose to Use Vaping Products

~~E- Cigarettes are not to be used on Counties Manukau Health premises in line with Ministry of Health Advice On E- Cigarettes.~~

Counties Manukau Health seeks to balance the objectives of 1) supporting people who smoke who choose to vape for smoking cessation or harm reduction and 2) protecting people, particularly children and young people, from risks associated with vaping.

People who choose to vape to quit smoking may do so only in designated outside areas within the Counties Manukau Health grounds. This includes vaping products~~e-cigarettes (vapes)~~ and other products that are not smoked (e.g. 'heat not burn' products).

Advice and support regarding the use of vaping products for smoking cessation and harm reduction is available from the Living Smokefree Service.

Smokefree Mental Health Services

Mental Health Services also seek to maintain and promote a smokefree environment at all times within Tiaho Mai, in accordance with this policy. This is more fully described in the Smokefree Tiaho Mai Procedure.

Staff Support

Staff are encouraged to attend the 'Smokefree Best Practice' training offered through the Learning and Development Unit to assist them to support all patients who ~~are~~ smoke~~rs~~ during hospitalisation, as well as whaanau and visitors where appropriate.

Counties Manukau Health is a significant employer within the Counties Manukau community, and as a leader in the drive to achieve a Smokefree Counties Manukau by 2025, the organisation actively encourages a smokefree workforce, and prioritises smokefree support for staff.

For staff who smoke:

- Nicotine Replacement Therapy (NRT) quit cards are provided by the Living Smokefree Service in order to help staff manage nicotine dependence while working at Counties Manukau Health or to make a Quit attempt. NRT is heavily subsidised with a quit card. Also, free NRT is made available through Living Smokefree Service.

For staff who want to quit smoking:

- Stop smoking support is offered by the Living Smokefree Service and the Occupational Health and Safety Service. This service is free to Counties Manukau Health staff. Staff are able to receive this help in work time subject to reasonable operational / staffing requirements.

The Living Smokefree Service will endeavour to explore new and innovative opportunities to assist staff to manage their smoking during work hours, to reduce their smoking and/or to stop wherever possible. The Living Smokefree Service can be contacted via Southnet, by emailing smokefree@middlemore.co.nz or by phoning extension 6094 (0800 569 568).

Staff Non-Compliance

For breaches of the Smokefree Policy, managers will discuss and address non-compliance with their staff member(s) and may do so in accordance with the CMDHB Code of Conduct and the Discipline and Dismissal Policy. This process will be supported by the relevant Human Resource Manager.

Where Security and/or other staff observe staff breaching the Smokefree Policy, they may reasonably remind the staff member of the organisation's policy, and request the name and area of work of the staff member. This information may be reported to the staff members' supervising manager. Refusal to cooperate with this process may be considered non-compliance with the Code of Conduct and treated appropriately.

Clinical Staff and Patient Care

Staff who are responsible for patient care are also encouraged to ensure the Smokefree Policy is discussed with patients on admission to hospital or presentation to clinics. Clinical staff are to identify people patients who smoke and advise patients of appropriate alternatives and support during their hospitalisation such as nicotine replacement therapy (NRT) and referral to the inpatient smoking cessation specialist and/or community cessation provider as appropriate.

Although staff cannot force a patient / client to stop smoking outside, staff should not actively facilitate or assist patients / clients to smoke on the hospital grounds and not escort any patient/client for the purpose of smoking) but should instead offer support and NRT. Where the primary concern is for patient safety this should be handled as such but without promoting smoking as a solution.

The Living Smokefree Service can provide guidance for staff and management on broaching this issue.

Patient Support

Counties Manukau Health offers support for those patients who wish to quit smoking including:

- Inpatients from all Counties Manukau Health hospitals
- Outpatients who have been referred from a Counties Manukau Health hospital or clinic

Such patients can be referred to the Living Smokefree Service on the Smokefree webpages via Southnet, by emailing smokefree@middlemore.co.nz, or on extension 6094 (0800 569 568)). People referred to the Living Smokefree Service will be offered subsidised medication, support during their hospital admission as required, and follow up treatment post discharge. Alternatively, patients may be referred to the patient's GP or other services in the PHO and the Quitline (0800 778 778) (national service)

Patients who require support for temporary abstinence of nicotine while hospitalised will be offered NRT, which will be charted on the patient's medication chart as part of their patient care management plan. See the Management of Nicotine Dependence Guideline and the accompanying Management of the Nicotine Dependent Patient Flowchart.

Patient and Visitor Non-Compliance

Security Staff will inform and assist with the enforcement of the Counties Manukau Health Smokefree Policy. However, it is the responsibility of all staff to inform other staff, patients and visitors who are found to be smoking on-site that Counties Manukau Health is smokefree at all times.

For the purposes of clarity, the Counties Manukau Health property boundary along Hospital Road includes up to the railway station, which includes the grass banks beside the railway line, and the Western Campus staff car park within the fence line along Orakau Road. The railway station, under responsibility of Auckland Transport, is also completely smokefree.

Support for Visitors

Parents of children who are admitted to Kidz First can be offered NRT for the duration of the child's / children's hospitalisation. All other visitors can be directed to local or regional services, or to the Quitline. For further information on these services contact the Living Smokefree Service.

Living Smokefree Service General Enquiries – ext 6094 or 0800 569 568

Health Promotion and Education

Health promotion is a strong focus of the Counties Manukau Health vision. As well as promoting smokefree throughout Counties Manukau Health, the Living Smokefree Service will provide appropriate smokefree promotion within the community to inform them of the Smokefree Policy. Information on the Living Smokefree Service and community-based smokefree services will be made available by all Counties Manukau Health services for patients, staff and all others who may benefit from it.

Staff Exposure to Second-Hand Smoke

Staff who are exposed to second hand smoke whilst on duty are encouraged to complete an Incident form and may report any concerns or issues regarding second hand smoking to the Living Smokefree Service who will follow through in accordance with Incident Process and Resolution Policy and Procedures.

Occupational exposure to second-hand smoke (SHS) is a proven health hazard and staff are entitled to take steps to minimise their exposure, in line with the existing Community/Home-based Visiting Policy. Staff may reasonably request that patients do not smoke whilst receiving care in their own or residential care premises. If staff cannot resolve this issue with clients themselves, they should seek support or advice from their line manager.

Complaints

Staff concerns relating to staff or others smoking or vaping can be documented on the Incidents Form and processed in accordance with Incident Process and Resolution Policy and Procedures.

Complaints about smoking or vaping from patients and / or visitors can be made to the Complaints Line on 277-1667 or extension 3667, or can be in writing or electronically (either by letter, in a happy/unhappy form, or via the Counties Manukau Health website).

Smokefree Systems

Counties Manukau Health is committed to a 'whole of systems' approach to Smokefree, and to ensuring that:

- Smoke-exposed patients are identified and offered NRT to manage their addiction;
- All front-line health staff are offered training in effective brief interventions for smoking cessation;
- Patients who are smokers receive frequent and brief interventions for smoking cessation; and
- A smoking cessation service is available to support patients and staff.

Definitions

Terms and abbreviations used in this document are described below:

Term/Abbreviation	Description
NRT	Nicotine Replacement Therapy
Quit Card	Exchange card for subsidised NRT 1 quit card = 12 weeks of NRT (can include up to 3 products) Cost: $5 per product (as of 01/01/13)

Associated Documents

Other documents relevant to this guideline are listed below:

NZ Legislation	• Smokefree Environments Act (1990) and Amendments (2003) • Health & Safety in Employment Act (HSEA) (1992) and Amendments (2002) • Smokefree Environments and Regulated Products (Vaping) Amendment Act 2020
NZ Standards	The New Zealand Guidelines for Helping People to Stop Smoking (MOH, 2014) http://www.health.govt.nz/publication/new-zealand-guidelines-helping-people-stop-smoking

Organisational Policies, Procedures, Protocols or Guidelines	~~Nicotine replacement therapy - Standing Order~~ Standing Orders for Nicotine Replacement Therapy Workbook (Available at Ko Awatea Learn) Management of Nicotine Dependence in Patients Who Smoke -Guideline Smokefree Tiaho Mai - Procedure Discipline and Dismissal Policy http://cmdhbdocuments/docsdir/opendocument.aspx?id=A5704 Dress Code Policy http://cmdhbdocuments/docsdir/opendocument.aspx?id=A5705

Update on the Smokefree Environments and Regulated Products (Vaping) Amendment Act

Presentation for the Counties Manukau Health Board

Date: 9 Dec 2020

Vaping Amendment Act: 1

- A substantial update to the Smokefree Environments Act 1990 to cover vaping and vaping products.
  - Introduces a new term “regulated products” (i.e. tobacco, vaping, and herbal smoking products) which broadens the regulatory scope of the Act and allows for flexibility to include new products under this legislation in the future.
- The Act aims to balance these two main concerns:
  - The harms associated with vaping – particularly for children and young people;
  - The benefits associated with vaping for people who smoke (i.e. switching to a less harmful product and use as a smoking cessation tool).

Vaping Amendment Act: 2

- Main changes:
  - prohibits vaping and use of smokeless tobacco products in legislated smokefree areas;
  - prohibits advertising, endorsements and sponsorship of vaping and smokeless tobacco products (with some exemptions);
  - prohibits sale & supply of regulated products to people <18 yrs;
  - enables, with controls, approved vaping premises (see next slide);
  - significantly restricts flavours (see next slide);
  - introduces a product notification scheme; and
  - introduces a regulatory mechanism to develop plain packaging, labelling and safety standards.
- Publicly-funded smoking cessation services can supply free or discounted vaping products to clients.

Vaping Amendment Act: 3

Specialist vs Generic Vape Retailers

COUNTIES MANUKAU HEALTH

	Specialist Vape Retailers	Generic Retailers
Retailer registration	✓ Must apply to the Director-General of Health to be an approved "specialist vape retailer" (criteria apply)	×
R18 premises	✓	× Regulated products must not be sold to people under 18 years of age
Reporting of sale information annually	✓	×
May use words like 'vape' and 'vaping' in trading names	✓	×
Vape liquid flavours	✓ All flavours (unless prohibited)	✓ Three flavours (tobacco, mint, menthol)
Vaping within premises	✓	×
May provide advice and demonstrations to customers	✓	× May do no more than identify the product and indicate the price
Give-aways, discounting and loyalty points for vaping products	✓	×
Online-only retail	×	✓

Vaping Amendment Act: 4

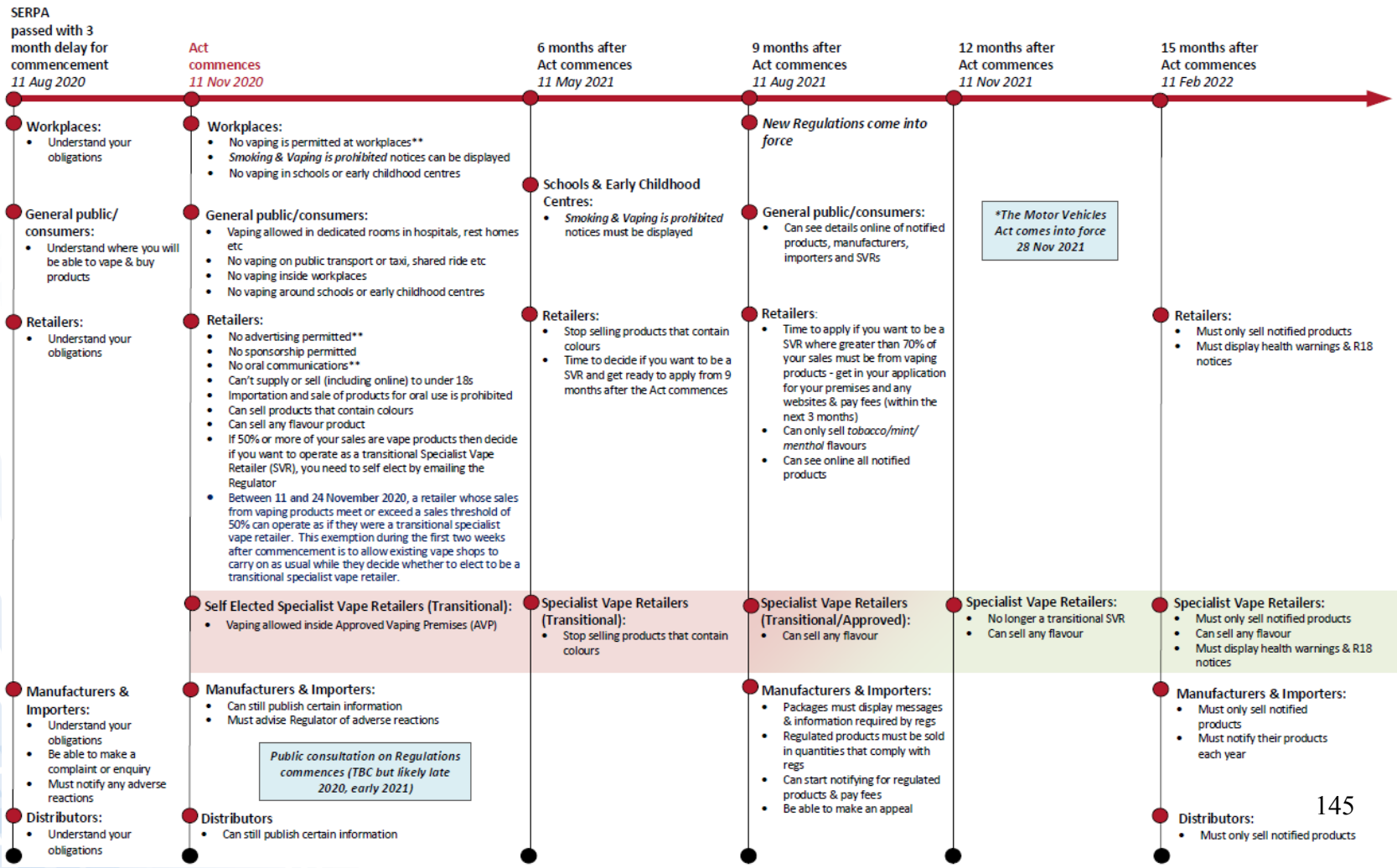
Timeline provided by Ministry of Health

COUNTIES MANUKAU HEALTH

Smokefree Environments and Regulated Products (Vaping) Amendment Act - Key Timeline

Purpose: Provide focus on key timeline messaging for external stakeholders

Please refer to the Smokefree Environments and Regulated Products (Vaping) Amendment Bill or the Guidance documents for further details*



Implications for CM Health: 1

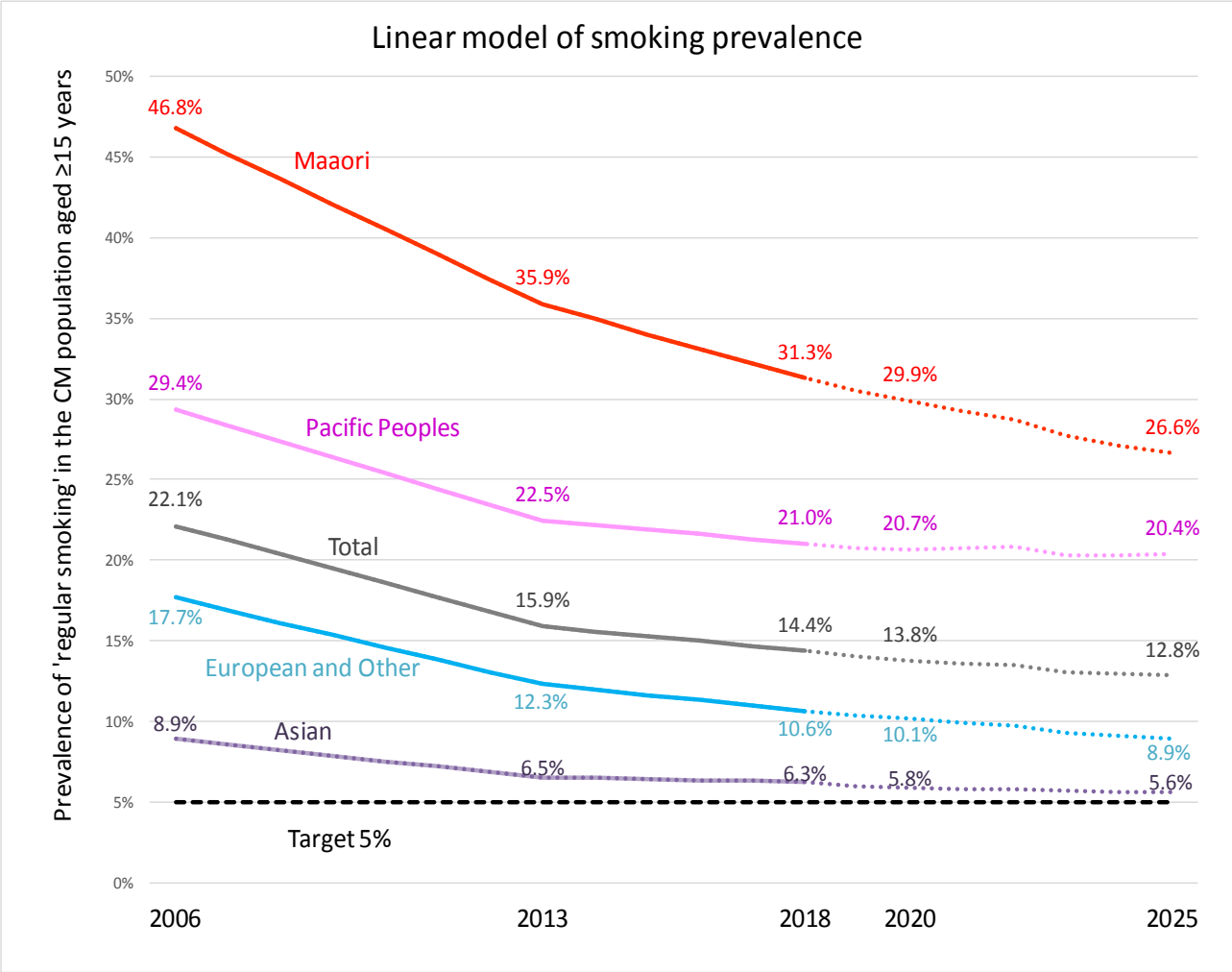
Vaping key messages

Our key messages related to vaping still hold and are consistent with the Act, i.e.:

1. Vaping is not harmless. People who don't smoke, including young people, should not be using these products.
2. Vaping is less harmful than smoking.
3. Vaping can help people who smoke to quit smoking.
    - Best done in conjunction with a smoking cessation service accompanied by behavioural support/counselling; and
    - With a view to completely switching from tobacco to vaping, and then to quitting vaping.

Implications for CM Health: 2

Stark inequities in smoking prevalence



- Smoking is one of the most significant preventable risk factors for premature death and morbidity.
- Key driver of inequities in health outcomes for Maaori & Pacific people.
- Smoking prevalence is reducing, but we are not on track to reach the Smokefree 2025 goal and stark inequities remain.

'Regular smoking' prevalence in adults, Census 2006, 2013 and 2018, with linear extrapolation to 2025 based on the change between 2013 and 2018, and using prioritised ethnicity

Implications for CM Health: 3

Vaping as a smoking cessation tool

- Vaping is an option that people can choose to help them with their journey to becoming smokefree; may help to reduce inequities.
- Data for Jan-Dec 2019 from the CM Health Living Smokefree Service show higher quit rates with vaping/e-cigarette use:

Living Smokefree Service clients by ethnic group	Target quit date set (n)	Smokefree at 4 weeks (n)	Quit rate (%)
All ethnic groups			
All clients	1240	980	79%
E-cigarette use	337	294	**87%**
No E-cigarette use	903	686	76%
Maaori			
All Maaori clients	625	491	79%
E-cigarette use	184	163	**89%**
No E-cigarette use	441	328	74%
Pacific Peoples			
All Pacific clients	320	253	79%
E-cigarette use	63	54	**86%**
No e-cigarette use	257	199	77%
Non-Maaori non-Pacific			
All non-Maaori non-Pacific clients	295	236	80%
E-cigarette use	90	77	**86%**
No E-cigarette use	205	159	78%

Implications for CM Health: 4

Client insights

Patrick McManus first approached the CMH Living Smokefree Service Quit Bus in December 2018 at a Christmas party for a local peer support group. He told the Smokefree Advisor that he *"was sick and tired of being sick and tired."* As part of his recovery, he wanted to be free of cigarettes as he had been smoking for nearly five decades. As a child, he would smoke his grandparent's cigarette butts.

He had used Nicotine Replacement Therapy (patches and lozenges) in the past and was keen to try them again. However it just wasn't enough to help him kick the habit for good.

"I was interested in trying an e-cigarette and mentioned this to the Smokefree Specialists. They were supportive of my choice and showed me the different options available, talked to me about the safety of e-cigarettes as a stop smoking tool and that I should aim to stop using an e-cigarette as well as I didn't want to replace one addiction with another. To support me the specialists welcomed me to attend drop-in clinics as regularly as I wanted. I was able to attend drop-in clinics in the community at venues where I frequented such as at the RI International and at Middlemore Hospital Western Campus which was on my way home and very convenient for me. Attending the clinics was essential to my recovery and smokefree journey. I received regular support from the Smokefree team and their encouragement kept me motivated to become smokefree and blow low Carbon Monoxide readings. I have been using an e-cigarette for a few months now and am currently five consecutive weeks smokefree. Eventually I plan to stop using e-cigarettes as well."

Shared with permission from Patrick

Implications for CM Health: 5

Dedicated vaping rooms or areas

- The amended Act allows for dedicated rooms to be designated for vaping if an organisation wishes (Part 1, Section 6 of the Act).
- Proposal for dedicated vaping areas within Middlemore Hospital grounds has previously been presented.
- The rationale for having a vaping area/room is to support inpatients in their smokefree journeys.

Part 1, Section 6

6 Dedicated rooms in hospital care institutions, residential disability care institutions, and rest homes

1) An employer may permit smoking or vaping by patients or residents of a workplace that is, or is part of, a hospital care institution, a residential disability care institution, or a rest home if-
    a) The smoking takes place only in 1 or more dedicated rooms for smoking; and
    b) The vaping takes place only in 1 or more dedicated rooms for vaping; and
    c) Each dedicated room is equipped with or connected to a mechanical ventilation system to which subsection (2) applies; and
    d) The employer has taken all reasonably practicable steps to minimise the escape of emissions from the dedicated rooms into any part of the workplace that is not a dedicated room; and
    e) For each dedicated room, an adequate equivalent room is available for patients or residents who wish to socialise in an atmosphere without emissions.

Summary

- The changes to the Smokefree legislation strike a balance by supporting vaping as a smoking cessation tool while also preventing the normalisation of vaping and protecting people who don't smoke, particularly children and young people, from the harms of vaping.
- Vaping has an important role as a smoking cessation tool and could help to reduce inequities in smoking prevalence.
- Smokefree work is a priority for CM Health.
  - The Living Smokefree Service is working hard to support clients who wish to quit smoking and staff have expertise in supporting clients who choose to vape to quit.
  - CM Health could introduce a dedicated vaping room (e.g. in the mental health inpatient area) to assist inpatients in their smokefree journeys.

Information Paper
Counties Manukau District Health Board
Update on Alcohol Harm Minimisation Programme 2016-2020

Recommendation

It is recommended that the Board:

Receive this report as requested at the August 2020 Board meeting.

Note this paper was endorsed by the Executive Leadership Team on 17 November 2020 to go forward to the Board.

Note the 4 year programme to date has had an investment of $990,000 a year.

Note that an evaluation is underway which will input into a refreshed programme next year.

Prepared and submitted by: Hinewai Pomare (Programme Manager, Alcohol Harm Minimisation) on behalf of Dr Gary Jackson (Director of Population Health).

Glossary

AHM Programme – Alcohol Harm Minimisation Programme
CM – Counties Manukau
FTE – Full time equivalent
PHO – Primary health organisation

Purpose

The CM Health Board has requested an update on CM Health's Alcohol Harm Minimisation Programme (as discussed in the meeting on 5th August, 2020). The purpose of this paper is to provide an overview of the activities and progress of CM Health's Alcohol Harm Minimisation Programme from 2016-2020.

Executive Summary

Counties Manukau Health (CM Health) cares about the achievement of equitable health and wellbeing for the population we serve. Harmful alcohol use is a significant burden to society and is a leading risk factor for health loss. Reduction of hazardous alcohol use and alcohol-related harm will contribute substantially to achieving the 'Healthy Together' strategic goal. CM Health has a dedicated Alcohol Harm Minimisation Programme with a strong equity and prevention approach. This prevention approach is focused on alcohol as a key determinant of population health, and wellbeing and equity outcomes. Since its establishment in late 2016 the AHM Programme has been driving activity in line with its Alcohol Action Plan. This paper outlines the background to this programme, its alignment to the Healthy Together Strategy, the key areas of focus, and highlights some of the Programme's key achievements to date. It also provides a high-level list of areas of focus for the next five years.

Background

Counties Manukau Health (CM Health) cares about the achievement of equitable health and wellbeing for the population we serve. Harmful alcohol use is a significant burden to society and is a leading risk factor for health loss in Counties Manukau and New Zealand - alcohol harm is estimated to cost the Government $7.8

billion per year[1]. In CM there is an inequitable burden of harm on Maaori, males, youth, and socio-economically deprived populations[2]. The consequences of hazardous alcohol consumption are borne by children (including those exposed to alcohol during pregnancy), whaanau, friends and the wider community. It also puts considerable pressure on the health sector, particularly emergency services, as well as on our police and justice systems.

Reduction of hazardous alcohol use and alcohol-related harm will contribute substantially to achieving the *'Healthy Together'*[3] strategic goal: "Together, the Counties Manukau health system will work with others to achieve equity in key health indicators for Maaori, Pacific and communities with health disparities by 2020." In a paper on *'Key Indicators as Measures of Health Equity for the CM Health population"*[4], hazardous use of alcohol was one of six recommended areas for focus and identification of key health indicators to track progress by 2020 towards health equity. In 2016, the CM Health Board endorsed the establishment of an Alcohol Harm Minimisation Programme, with dedicated funding and FTE. Since then the programme team have developed an Action Plan '*Counties Manukau Health System Alcohol Action Plan 2016-2020'* and Logic Model, and have begun implementing the key actions within this plan.

The AHM Programme and its Action Plan focus on alcohol as a key determinant of population health and wellbeing outcomes and prioritises prevention and early intervention actions.

Te Tiriti o Waitangi

CM Health is committed to honouring and demonstrating its obligations and responsibilities to enact Te Tiriti o Waitangi. The principles of Te Tiriti o Waitangi, as articulated by the Courts and the Waitangi Tribunal, provide the framework for how the health system will meet our obligations under Te Tiriti in our day-to-day work. The 2019 *Hauora*[5] report recommends the following principles for the primary health care system. These principles are applicable to wider health and disability system, and the Ministry of Health have an expression of these principles. The principles that apply to the work in the health system are:

- **Tino rangatiratanga:** The guarantee of tino rangatiratanga, which provides for Maaori self-determination and mana motuhake in the design, delivery, and monitoring of health and disability services.
- **Equity:** The principle of equity, which requires the Crown to commit to achieving equitable health outcomes for Maaori.
- **Active protection:** The principle of active protection, which requires the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Maaori. This includes ensuring that it, its agents, and its Treaty partner are well informed on the extent, and nature, of both Maaori health outcomes and efforts to achieve Maaori health equity.
- **Options:** The principle of options, which requires the Crown to provide for and properly resource kaupapa Maaori health and disability services. Furthermore, the Crown is obliged to ensure that all health and disability services are provided in a culturally appropriate way that recognises and supports the expression of hauora Maaori models of care.
- **Partnership:** The principle of partnership, which requires the Crown and Maaori to work in partnership in the governance, design, delivery, and monitoring of health and disability services. Maaori must be co-designers, with the Crown, of the primary health system for Maaori.

For the Alcohol Harm Minimisation Programme the commitment to supporting Maaori leadership in taking action on alcohol harm includes the Waitangi Tribunal Alcohol Claim, within the *WAI 2575 Health Services and Outcomes Kaupapa Inquiry*.

[1] Nana G. (2018). Alcohol costs - but, who pays? Alcohol Action Conference "Who should pay for all the harm from alcohol?", 15 August 2018. Wellington, New Zealand.
[2] CM Health Alcohol Position Statement 2017: https://countiesmanukau.health.nz/assets/About-CMH/Reports-and-planning/84d554e090/CM-Health-Alcohol-position-statement-2017-updated.pdf
[3] Counties Manukau Health. Healthy Together, Strategic Plan, 2015-2020
[4] Key Indicators as Measures of Health Equity for the CM Health population. Population Health Team, Nov 2015
[5] Waitangi Tribunal. (2019). Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry.

Equity

Alcohol-related harms are major contributors to inequities in health and wellbeing outcomes. CM district has an ethnically diverse population with strong cultural values. It is home to New Zealand's second largest Maaori population and largest population of Pacific peoples. Alcohol-related inequities are evident for Maaori people, men, young people, and those living in the most socioeconomically deprived areas[6]. Overall, about 1 in 7 adults in CM Health drink in a way that is considered hazardous or harmful. In adults who drink (i.e. excluding those who have not had any alcohol in the past year), approximately 1 in 5 adults in CM Health drink in a hazardous or harmful way. Prevalence of hazardous alcohol use in Maaori is disproportionately high at 29%[6] of adults. Although many Pacific people do not drink alcohol at all, Pacific adults that do drink alcohol are more likely to have a hazardous drinking pattern than non-Pacific adults[7]. For people living in the Counties Manukau district there are, on average, five alcohol off-licence[i] premises within a five minute drive, and 30 off-licence premises within a 10-minute drive of where people live. Furthermore, one quarter of the schools and preschools are located within a five minute walk of at least one off-licence premise, and over half are located within a 10-minute walk of at least one off-licence premise.

Substantial population burden and inequities from alcohol-related harm. Alcohol use indicators for the CM Health Population[6]:

Alcohol use indicators	Maaori	Pacific	Asian	Euro/ other	Total
Percentage of people who drank alcohol (in past year)	80%	52%	52%	82%	67%
Hazardous alcohol use*	36%	35%	6%	20%	20%
Heavy drinking at least monthly*	29%	34%	11%	21%	21%
Heavy drinking at least weekly*	16%	20%	3%	13%	12%
* *In people who drank alcohol in the past year.*					

Reduction of hazardous alcohol use and alcohol-related harm will contribute substantially to achieving the 'Healthy Together' strategic goal: "Together, the Counties Manukau health system will work with others to achieve equity in key health indicators for Maaori, Pacific and communities with health disparities by 2025." CM Health supports working together with people, whaanau, families, communities, health agencies and other partners to influecnce the social and evironmental determinants of hazardous alcohol use and improve access to healthcare services for people experiencing alcohol-related harm.

Overview of the AHM Programme

The *He Ara Oranga* (Mental Health and Addiction Inquiry Report), the *WAI 2575 Health Services and Outcomes Kaupapa Inquiry* and the World Health Organisation have urged the Government to do more in addressing alcohol-related harm in New Zealand. While there has been limited progress made nationally in the last few years, our DHB has lead the way and made a commitment towards reducing alcohol related harm. This includes dedicated funding of $990,000 annually, with an FTE amount of four (one Programme Manager and three Advisors), towards the development and implementation of an Alcohol Harm Minimisation Programme.

The AHM Programme takes a strong equity and prevention approach. This prevention approach is focused on alcohol as a key determinant of population health, and wellbeing and equity outcomes and is based on

[i] Bottle stores, licensed supermarkets and grocery stores

[6] Data are from the NZ Health Survey for the CM Health area, pooled crude data for 2018 and 2019, total response ethnicity

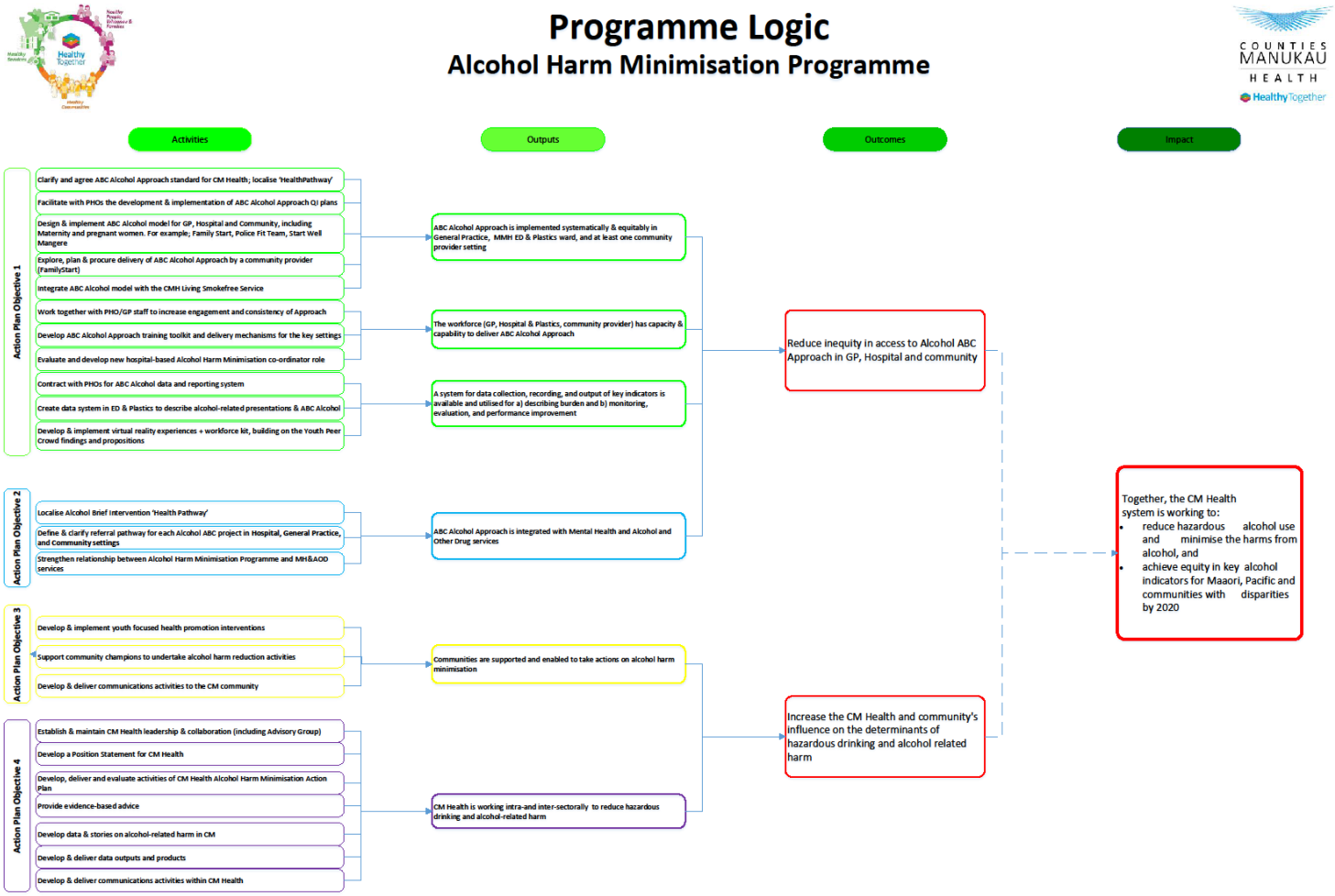
[7] Ministry of Health. 2016. Annual Update of Key Results 2015/16: New Zealand Health Survey. Wellington: Ministry of Health

the following:

- Implementing the Alcohol ABC approach – **A**ssessment, **B**rief advice, and referral to services for **C**ounselling or other help when needed. This involves supporting front-line staff across the health system (e.g. in general practice, ED, maternity/midwifery settings, inpatient wards, and outpatient clinics). This is an evidence-based, cost-effective strategy for reducing alcohol-related harm.

- Working with communities and intersectoral partners to influence the social and environmental determinants of hazardous and harmful alcohol use, particularly the most pro-equity, cost-effective 'best-buy' strategies - policies that increase the price of alcohol, restrictions to alcohol availability in the community, and regulation of alcohol advertising, marketing, and sponsorship.

The AHM Programme Logic Model is attached below:



Key Achievements in the AHM Programme 2016-2020

Since its beginning in late 2016, the AHM Programme has achieved several key milestones. We have outlined some of these below, in line with the four key objectives of the AHM Programme. This is not an exhaustive list but an overview of some of the achievements to date. These include:

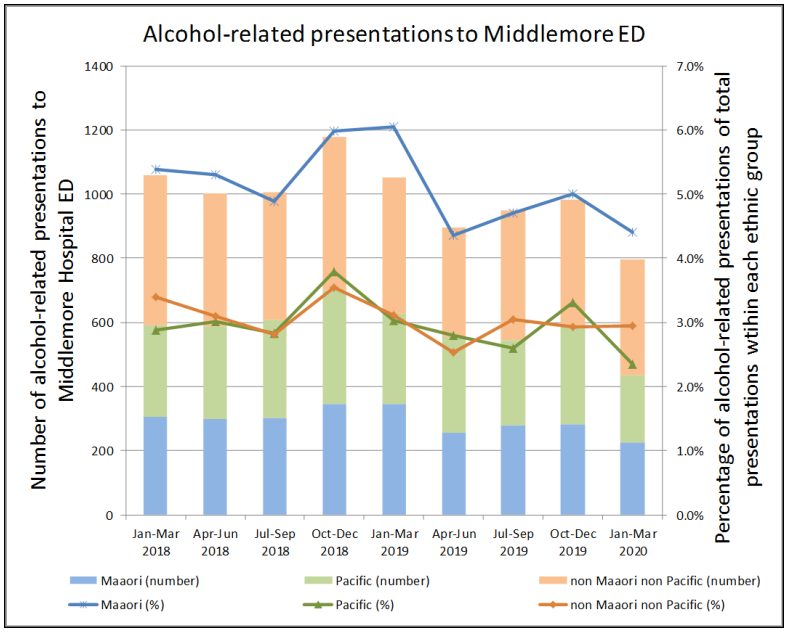
Objective 1 & 2: Implementing the Alcohol ABC approach

Objective 1 *'Implement or further develop a systematic, sustainable, and equitable Alcohol ABC Approach in three key health settings', and* Objective 2 *'Strengthen integration between the Alcohol ABC Approach and Mental Health and Alcohol and Other Drug (AOD) services'*

- Establishing Alcohol ABC projects and embedding the Alcohol ABC Approach in four key settings: - emergency department, Smokefree, general practice and Hand Therapy;
- Procuring and contracting with primary healthcare providers since 2017 to deliver services which has enabled us to have baseline data and subsequently routinely collected data on Alcohol ABC which

was not previously available, and the first of its kind nationally as far as we're aware;

- We now have over 20 collaborating general practices across the 5 CM PHO's that we work with more intensely to embed the Alcohol ABC Approach, trial innovative projects and apply quality improvement approaches;
- Setting up and coordinating regular Alcohol ABC training sessions for CM Health and general practice staff. We have now had over 300 staff trained in 'Having Conversations about Alcohol';
- Setting up a team of advisors and champions to drive the work in the AHM Programme, with an advisor leading work in each of the key settings. This includes 0.2FTE of an ED nurse as the clinical lead in ED;
- Routinely collecting data in each of the four key settings so that we are able to measure the burden of alcohol harm on our community and health system. For example, we estimate that there are approximately 1,000 presentations to Middlemore Hospital (MMH) ED per quarter directly associated with alcohol[8]:



Objective 3 & 4: Working with communities and intersectoral partners to influence the social and environmental determinants of hazardous and harmful alcohol use

Objective 3 *'Support and enable communities/groups to take actions on alcohol harm reduction'*, and Objective 4 *'Working intra and inter-sectorally to reduce hazardous alcohol related harm'*

- Working with health sector partners to influence the determinants of hazardous drinking and alcohol related harm. For example, working alongside Alcohol Healthwatch to advocate for best-practice pregnancy warning labels on alcohol;
- Championing innovative youth-focused health promotion interventions such as the Youth Peer Crowd programme of work – 'The Movement', alongside health sector partners Health Promotion Agency, CAYAD (Auckland Council), Healthy Families, Sport New Zealand and the NZ Drug Foundation;
- Hosting the first ever national Waipiro Symposium in 2019 at CM Health alongside partners Haapai Te Hauora, the Health Promotion Agency (HPA), Kookiri ki Taamakimakaurau Trust and the National Hauora Coalition, and attended by over 40 delegates from across the country;
- Being chosen by health sector partners such as Te Hiringa Hauora (Health Promotion Agency) to partner on projects and localise national health promotion campaigns so that they were more targeted and relevant to the CM population. An example of this is the HPA's 'Pre-Testie Bestie campaign'. We were also able to generate over $45k in revenue to support the development of further alcohol harm campaigns in CM that will then be used nationally by other DHB's and health

[8] CM Health analysis, based on 'alcohol flag' data from the Ministry of Health's National Non-Admitted Patient Collection, using the prioritised ethnicity data output method.

providers;
- Publishing two data reports '*CM Health Alcohol Related Harm Profile'*[9] and *'Alcohol-Involved Emergency Department Encounters and Hospital Admissions at Middlemore Hospital in 2018'*[10] that have been used by community members and health sector partners in their objections to off-license applications.

Across all four objectives of the Alcohol Harm Minimisation Programme

- Being the first DHB in the country to implement a programme such as this with a whole-of-system approach, from clinical settings in secondary and primary care right through to the community;
- Creating a logic model and action plan to guide this work, which is used by our CM Health Evaluation Team as an example of best practice. We have also developed an evaluation plan for the Programme and have an evaluation of the programme currently underway;
- Taking a strong equity approach across the programme, such as implementing a population-based formula for funding and creating equity specific targets with lead practices within the primary care contracts. Another example of this are the final contract payments of the PHO Agreements being contingent on the PHO's not only improving on their baseline data but achieving this equitably;
- Creating a position statement for alcohol for CM Health. This is the first position statement for CM Health and was the first position statement to be adopted and published of any of the three Auckland-metro DHB's[2];
- Creating and delivering a range of communications activities. This included the creation of Personas that have then been used as the base when developing workforce development training videos for staff; working with social media influencers on targeted campaigns that saw tens of thousands of engagements; in-person hospital promotion days; community activation events; the development of a Creative Foundation and AHM branding.

Current challenges

While there have been many successes in the last four years, there have also been several challenges. One of the primary difficulties at a macro level has been the lack of national leadership in the alcohol space in previous years. This is due in part to the distributed responsibility across Government agencies. The Ministry of Health is the policy lead on alcohol harm while the Ministry of Justice administers the Sale and Supply of Alcohol Act 2012. Te Hiringa Hauora Health Promotion Agency (HPA) is the Crown Entity with legislative responsibility for researching and advising on the sale, supply, consumption, misuse, and harm of alcohol. Reducing alcohol harm relies on agencies such as the Ministry of Health, HPA, Ministry of Justice, the New Zealand Police, the Ministry of Transport, Accident Compensation Corporation working together.

The '5+ Solution' are evidence-based strategies recommended by the World Health Organisation as national areas for action in the global strategy to reduce the harmful use of alcohol. These are:
- Restricting the availability of alcohol
- Increasing the minimum legal purchasing age
- Increasing the price of alcohol
- Addressing alcohol advertising, promotion and sponsorship
- Drink driving countermeasures.

The formation of the National Public Health Advisory Steering Group, supported by DHB Chief Executives and Chairs, provides a further advocacy route to progress action on alcohol, diet and obesity issues.

At the programme and project level, one of the key difficulties has been the lack of IT enablement. For example, in the emergency department where there are a mix of patient management systems that are

[9] CM Health Alcohol Related Harm Profile: https://countiesmanukau.health.nz/assets/About-CMH/Performance-and-planning/health-status/729b26e0a4/20180710-CMH-Alcohol-Related-Harm-Profile.pdf
[10] Alcohol-Involved Emergency Department Encounters and Hospital Admissions at Middlemore Hospital in 2018: https://countiesmanukau.health.nz/assets/About-CMH/Performance-and-planning/health-status/2019_Counties_Manukau-Health_Alcohol-involved-encounters-MMH.pdf

poorly aligned and result in a large number of patients missing the opportunity for alcohol assessment and brief intervention, or the duplication of the question being asked. Another difficulty that has delayed progress in embedding the Alcohol ABC Approach in the inpatient setting is the busyness of settings, and staff therefore not feeling that they have the time to ask their patients about alcohol. In some instances a decision has been made in that setting that no assessments will be done during periods of busyness. The inpatient area's where there have been successful implementions of Alcohol ABC are areas that have good high-level buy-in from all levels of management.

AHM Programme next steps and priority actions 2020 to 2025

The following actions build on the previous four years of significant work from the Alcohol Harm Minimisation Programme in CM Health. These actions have been aligned to the four objectives of CM Health's Alcohol Harm Minimisation Action Plan. It also important to note that there is currently an evaluation underway and the findings from this will inform an updated version of the focus areas listed below.

Objectives 1 & 2: Implementing the Alcohol ABC approach

1. Explore the opportunities to develop a Māori Model of delivering Alcohol ABC.
2. Expand Alcohol ABC to the hospital wards and wider in primary care. Build on successful implementation in PHO and other settings and develop a programme of work in Maternity.
3. Build the workforce capability and capacity including set up of a systematised approach to WFD Training: Toolkit developed and rolled out; trainings mandatory and embedded; Champions system across the settings; resources and collateral.

Objective 3 & 4: Working with communities and intersectoral partners to influence the social and environmental determinants of hazardous and harmful alcohol use

4. Continue to support community action on alcohol harm, such as the focus on collaborative youth initiatives: Youth Peer Crowd and KuraConnect, and the Waitangi Tribunal Alcohol Claim.
5. Continue to work with our health sector partners to advocate for greater action on alcohol harm.

Across all four objectives:

6. Communications: Continue to build on the communications work to date to progress key AHM activities across the settings, including highly-targeted media campaigns, use of Persona's, collateral material.

Appendices

1. CM Health Alcohol Position Statement (*attached separately)*
2. Photos of a selection of key pieces of work to date.

TAMATI

30 Years Old | Mangere

COUNTIES MANUKAU HEALTH

Tamati works in construction, and is studying to become a sparky. Alcohol has always been a big part of his family's social gatherings. Tamati thinks his drinking and lifestyle is normal.

- Spends most of his free time drinking with mates or in his room
- Drinking and socialising are intertwined
- Normally drinks with 'the boys' or family members
- On average consumes 40+ standard drinks during a week and a couple of boxes during a weekend session
- Doesn't see any problems with the way he drinks

Education and employment

Tamati currently works in construction, and he is studying to become a sparky. He went to De la Salle College where he finished NCEA level 1 but left school during Y12.

Home life

Tamati lives with his partner and their three kids. In his downtime, he watches lots of YouTube videos, and also enjoys listening to music.

Influences

Tamati is hugely influenced by his family and friends and he still has a good group of friends from 'back in the day'. He and his friends started drinking when they were 13. He also gets a lot of pressure to drink through sports teams and parties.

Social life

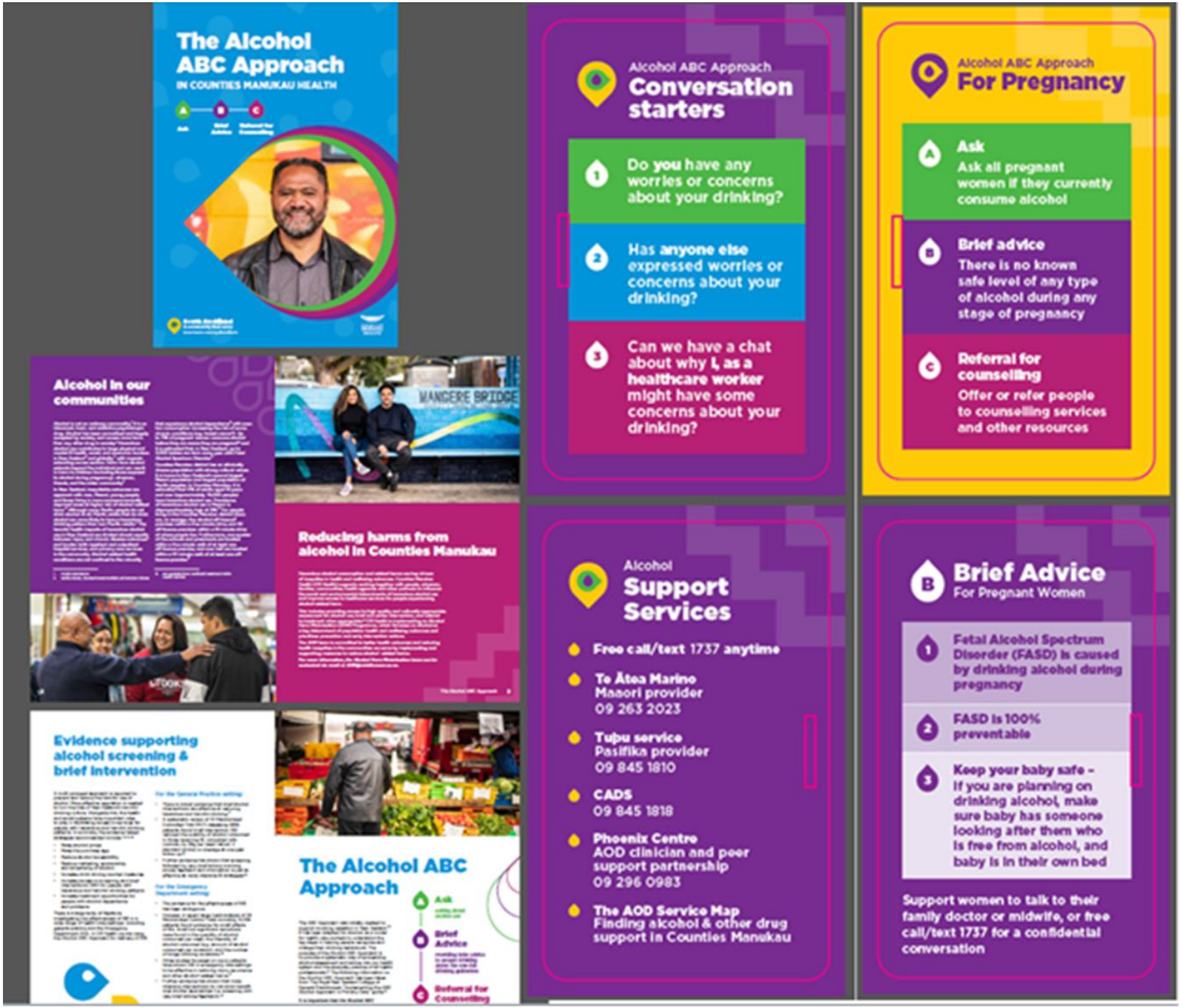
Tamati is particularly close with a group of men he went to school with. They spend a lot of time together drinking and talking about their 'glory days'. He is known to drink a couple of boxes of beer with his mates on a Saturday night, and during the week will also drink in the garage with his Dad, brother or nephews - whoever is around.

Relationship with alcohol

Tamati is a regular drinker. He is often hungover in the weekend when his kids are home, which means he can't hang out with them. He believes that a 'bad night' - a night where he ends up in a fight with someone and very hungover the next day - is actually a sign of a good night. If someone was to suggest he had a problem, he would just think they were nosey, he doesn't believe in 'getting help'.

This was the final phase of the localisation of the Pre-Testie Bestie, which saw us working with HPA, their marketing company and social media influencers to produce video content for Instagram that would be engaging for the target audience. Of the three videos produced, the South Auckland video garnered the most engagement (views, likes, comments and shares).
Within a one week period, the South Auckland targeted material proved to be the most popular, with:

42+k views	**180+** comments


The Alcohol ABC Approach
IN COUNTIES MANUKAU HEALTH
Alcohol ABC Approach
Conversation starters
1 Do you have any worries or concerns about your drinking?
2 Has anyone else expressed worries or concerns about your drinking?
3 Can we have a chat about why I, as a healthcare worker might have some concerns about your drinking?
Alcohol ABC Approach
For Pregnancy
A Ask
Ask all pregnant women if they currently consume alcohol
B Brief advice
There is no known safe level of any type of alcohol during any stage of pregnancy
C Referral for counselling
Offer or refer people to counselling services and other resources
Alcohol in our communities
MANGERE BRIDGE
Reducing harms from alcohol in Counties Manukau
Alcohol
Support Services
Free call/text 1737 anytime
Te Ātea Marino
Māori provider
09 263 2023
Tupu service
Pasifika provider
09 845 1810
CADS
09 845 1818
Phoenix Centre
AOD clinician and peer support partnership
09 296 0983
The AOD Service Map
Finding alcohol & other drug support in Counties Manukau
B Brief Advice
For Pregnant Women
1 Fetal Alcohol Spectrum Disorder (FASD) is caused by drinking alcohol during pregnancy
2 FASD is 100% preventable
3 Keep your baby safe – If you are planning on drinking alcohol, make sure baby has someone looking after them who is free from alcohol, and baby is in their own bed
Support women to talk to their family doctor or midwife, or free call/text 1737 for a confidential conversation
Evidence supporting alcohol screening & brief intervention
The Alcohol ABC Approach
Ask
Brief Advice
Referral for Counselling

Reducing harms from alcohol in our communities

Position statement

Counties Manukau Health (CM Health) cares about the achievement of equitable health and wellbeing for the population we serve. Alcohol-related harms are major contributors to inequities in health and wellbeing outcomes. We support working together with people, whaanau, families, communities, health agencies and other partners to influence the social and environmental determinants of hazardous alcohol use and improve access to healthcare services for people experiencing alcohol-related harm.

1. We support a broad and comprehensive package of evidence-based strategies that equitably prevent and reduce hazardous alcohol use and alcohol-related harm including:
    - restricting the availability of alcohol
    - increasing the minimum legal purchase age
    - increasing the price of alcohol
    - reducing alcohol advertising, promotion and sponsorship
    - drink driving countermeasures.
2. We support equitable access to high quality and culturally-appropriate healthcare services including assessment for hazardous alcohol use, brief and earlier intervention, and referral to treatment when indicated.
3. We support improving and refining information on hazardous alcohol use and alcohol-related harm in the Counties Manukau population and the geographical area we serve.
4. We support and encourage research and evaluation to ensure interventions targeting hazardous alcohol use and alcohol-related harm are effective and equitable.

Alcohol in our communities

Alcohol is not an ordinary commodity.[1] It is an intoxicant, toxin, and addictive psychotropic drug. Alcohol has been normalised and largely accepted by society, and causes more harm than any other drug in society.[2] Hazardous alcohol use contributes to large physical and mental ill-health, social, and economic burdens in New Zealand[3] and globally,[4] with impacts extending across sectors. Harm from alcohol extends beyond the individual and can result in harm to children (including those exposed to alcohol during pregnancy), whaanau, friends, and the wider community.[5]

In New Zealand, inequitable outcomes are apparent with men, Maaori, young people, and those living in more socioeconomically deprived areas at higher risk of alcohol-related harm.[6] Although many Pacific people do not drink alcohol at all, Pacific adults that do drink alcohol are more likely to have a hazardous drinking pattern than non-Pacific adults.[7] The harmful health impacts of hazardous alcohol use in New Zealand are divided almost equally between injury and chronic disease outcomes[3] and burden both inpatient and outpatient hospital

services, and primary care services in the community. Alcohol-related health conditions are not confined to the minority that experience alcohol dependence[8] with even low consumption increasing the risk of some chronic conditions (e.g. breast cancer[9]).

Counties Manukau district has an ethnically diverse population with strong cultural values. It is home to New Zealand's second largest Maaori population and largest population of Pacific peoples. In Counties Manukau, it is estimated[i] that 13% of adults aged 15 years and over (approximately 50,000 people) have hazardous alcohol use. Prevalence of hazardous alcohol use in Maaori is disproportionately high at 29%.[10] For people living in the Counties Manukau district there are, on average, five alcohol off-licence[ii] premises within a five minute drive, and 30 off-licence premises within a 10-minute drive of where people live. Furthermore, one quarter of the schools and preschools are located within a five minute walk of at least one off-licence premise, and over half are located within a 10-minute walk of at least one off-licence premise.[iii]

Rationale for our position

Hazardous and harmful alcohol use is identified as a major contributor to inequities and is amenable to healthy public policy.[11] Each of the evidence-based strategies below is identified as an area for national action in the World Health Organization 2010 Global strategy to reduce the harmful use of alcohol.[12]

1. **Equitable prevention of hazardous alcohol use and alcohol-related harm**

- **Restricting the availability of alcohol**
  - Increased alcohol outlet density is associated with increased alcohol-related harm.[13] Alcohol outlets are inequitably distributed in New Zealand with more alcohol outlets situated in socioeconomically deprived areas,[14] further contributing to the unequal distribution of harm. There is strong evidence pertaining to the beneficial effects of reduced trading hours on alcohol-related harm.[15]
- **Increasing the minimum legal purchase age**
  - Young people are more vulnerable to alcohol-related harm than other age groups.[4] Alcohol use during mid-to-late adolescence is associated with impacts on brain development.[16] Raising the purchase age reduces adolescent access to alcohol, reduces harmful youth drinking, and raises the age at which young people start drinking.[1]
- **Increasing the price of alcohol**
  - Raising alcohol prices is internationally recognised as an effective way to reduce alcohol-related harm.[17] Policies that increase the price of alcohol delay the start of drinking, reduce the volume consumed per occasion by young people, and have a greater effect on heavy drinkers.[18]

[i] Crude prevalence
[ii] Bottle stores, licensed supermarkets and grocery stores
[iii] GIS analysis from Auckland Regional Public Health Service

- **Addressing alcohol advertising, promotion and sponsorship**
  - Alcohol advertising and promotion increases the likelihood that adolescents will start to use alcohol, drink more if they are already consuming alcohol,[19] and makes it more difficult for hazardous users of alcohol to abstain.[20]
- **Drink driving countermeasures**
  - The risk of motor vehicle accidents increases exponentially with increasing alcohol consumption.[21] In New Zealand, it has been estimated that over a quarter of road traffic injuries across all road user groups involve alcohol.[5] Laws setting a low level of blood alcohol concentration at which one may drive legally and well-publicised enforcement significantly reduce drink-driving and alcohol-related driving fatalities.[1]

2. **Equitable access to high quality and culturally-appropriate healthcare services**
   - Assessment, brief advice, and referral to specialist services when indicated in healthcare settings (e.g. general practice[22] and Emergency Departments[23]) reduce hazardous drinking and alcohol-related harms. Detoxification is an effective treatment for alcohol dependence and addiction.[1]
3. **Improving and refining information on hazardous alcohol use and alcohol-related harm**
   - Robust data are needed to accurately describe the burden from alcohol, inform decisions on what strategies and initiatives to develop and fund,[12] and support our communities and intersectoral partners with their alcohol data needs.
4. **Research and evaluation to ensure effective and equitable interventions**
   - Research is needed to identify evidence-based interventions for the communities we serve. Evaluation is required to measure the effectiveness of implementation and impact on equity.

Policy and legislative environment

CM Health's position on alcohol in our communities has been developed in the context of the national policy and legislation outlined below. Additionally, the principles of Te Tiriti o Waitangi[iv] and the United Nations Declaration on the Rights of Indigenous Peoples[v] necessitate comprehensive strategies that address longstanding inequities in alcohol-related harm between Maaori and non-Maaori.

National Drug Policy 2015 to 2020

The National Drug Policy[24] frames alcohol and other drug (AOD) problems as, first and foremost, health issues. The Policy aims to minimise AOD-related harm and protect health and wellbeing by delaying the uptake of AOD by young people, reducing illness and injury from AOD, reducing hazardous drinking of alcohol, and shifting attitudes towards AOD. Evidence-based strategies included in the Policy are:

[iv] Te Tiriti o Waitangi principles: **Participation, partnership, and protection**
[v] Ratified by New Zealand in 2010

- **Problem limitation:** Reduce harm that is already occurring to those who use AOD or those affected by someone else's AOD use through safer use, ensuring access to quality AOD treatment services, and supporting people in recovery.
- **Demand reduction:** Reduce the desire to use AOD through education, health promotion, advertising and marketing restrictions, and influence conditions that promote AOD use.
- **Supply control:** Prevent or reduce the availability of AOD through border control, supply restrictions, licensing conditions and permitted trading hours.

The Sale and Supply of Alcohol Act 2012

This Act[25], replacing the previous Sale of Liquor Act 1989, adopts a harm minimisation approach. Its adoption followed a lengthy review by the Law Commission[8] which recommended greater restrictions to the sale and supply of alcohol. Compared to the previous Act, alcohol-related harm is more broadly defined as both direct and indirect harm to an individual, society or the community caused by the excessive or inappropriate consumption of alcohol. The Act provides for Territorial Authorities (TAs) to develop and implement a Local Alcohol Policy (LAP). The aim of a LAP is to minimise alcohol-related harm through measures to control the local availability of alcohol. Ideally, they should address local concerns and target inequities in alcohol-related harm. LAPs are drafted in consultation with the police, alcohol licensing inspectors, and Medical Officers of Health (MOoH), and include community input.

The Counties Manukau district spans three TAs, all of which have either adopted LAPs (Hauraki and Waikato District Councils[vi]) or are progressing towards adopting LAPs (Auckland Council[vii]). The two adopted LAPs place proximity limits on new off-licences with reference to facilities (schools, early childhood centres and playgrounds) and other off-licences. The Provisional Auckland Council LAP places a two-year freeze on new off-licences in 23 areas that experience high levels of harm, 13 of which are in the Counties Manukau area. All three TAs have restricted maximum trading hours for both off and on-licences[viii].

The Act has increased the role of the MOoH in the licensing process, whereby they are now required to inquire into most licensing applications[ix] and provide input into LAPs. In the Auckland region, this role is provided by the Auckland Regional Public Health Service on behalf of all three metro Auckland District Health Boards including CM Health. District Health Boards are required to respond to TA requests for alcohol-related health information to inform their LAP.

[vi] LAPs at http://www.hauraki-dc.govt.nz/assets/council_documents/Policies/LocalAlcoholPolicy2016.pdf and https://wdcsitefinity.blob.core.windows.net/sitefinity-storage/docs/default-source/your-council/plans-policies-and-bylaws/policies/local-alcohol-policy-2017.pdf?sfvrsn=8522bbc9_4

[vii] Provisional LAP available at https://www.aucklandcouncil.govt.nz/plans-projects-policies-reports-bylaws/our-policies/provisionallocalalcoholpolicy/provisionallap.pdf

[viii] Premise where the sale, supply and consumption of alcohol is authorised on site (ie- Hotel, restaurant, bar)

[ix] Includes on, off, and club licence applications

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26 November 2020

On behalf of the Franklin Localities Leadership Group, I am pleased to provide you with a formal proposal for consideration by Counties Manukau Health for future community health services within the Franklin Locality.

This proposal has been developed by the LLG as a response to our assessment of community health needs, recognising the commitment CM Health has made to the Localities model as a tangible mechanism to improve access to our widely spread and in some cases, vulnerable communities to the wide range of much needed health and wellbeing services provided by CM Health.

We have recognised the challenges faced by CM Health and have carefully considered opportunities that we believe are achievable and would be of significant benefit to not only our communities but CM Health.

Whilst the CM Health area of responsibility has a large urban area, much of it with disproportionately high levels of social deprivation, it is also made up of a large rural or semi-rural population spread over numerous towns, villages and settlements. These communities all contain people who require access to basic and specialised services and for the most part this currently requires them to travel long distances to the larger medical facilities at Middlemore and Manukau. This travel requirement is known to be an impediment and deterrent for many which ultimately has long term health and economic impacts.

The Franklin Locality is committed to ensure that our rural communities have the best possible access to improved and equitable integrated health and wellbeing services that recognise the significant growth and development occurring with the Locality, in particular the north Waikato and Franklin areas. Pukekohe has been and will remain the social centre for those communities and thus enhancing the existing services through investment and improvement at the Pukekohe Hospital site should be a priority for CM Health.

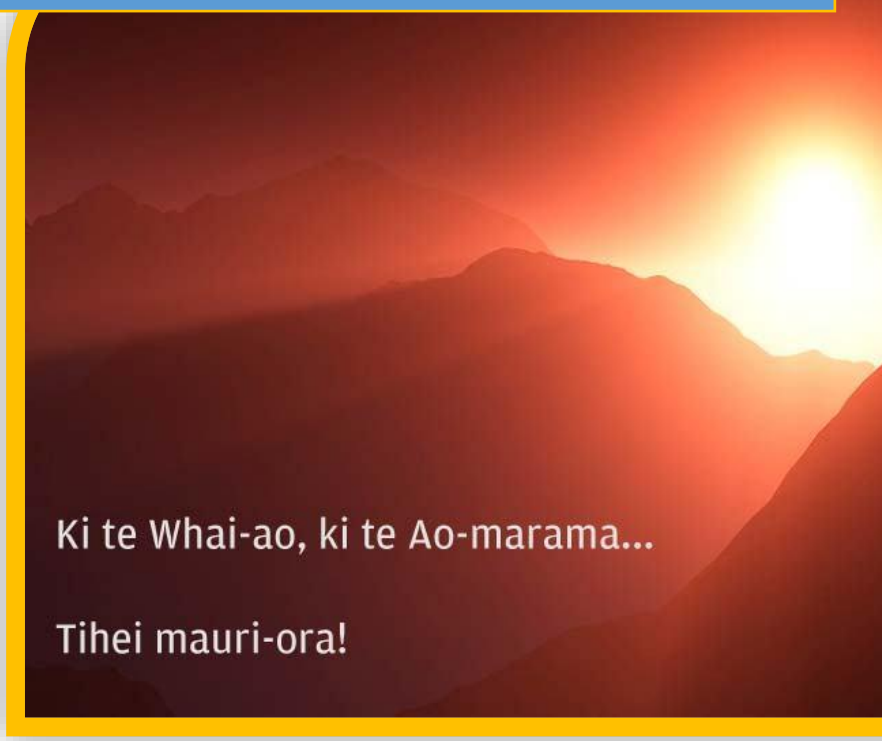
I ask that this proposal be presented to the CM District Health Board for consideration. We would welcome the opportunity to discuss this further to enable a pathway to the localised delivery of key services as first envisaged when the innovative Localities model was adopted.

I thank you in anticipation of the proposal being presented to the CMDHB and commend it to you.

Yours faithfully

Andrew Baker
Chair
Franklin Localities Leadership Group

Proposal



Localities Leadership Group
Franklin
25 November 2020

CONSIDERATION OF THE FUTURE COMMUNITY HEALTH SERVICES IN FRANKLIN:
A REPORT BY THE FRANKLIN LOCALITY LEADERSHIP GROUP FOR THE COUNTIES MANUKAU HEALTH

Executive Summary

This is a report from the Franklin Locality Leadership Group (LLG) to the Counties Manukau DHB (CMDHB). The purpose of the report is to highlight some of the key issues the LLG believes impact on the current provision of health services in Franklin and proposes some potential solutions for consideration by the CMDHB. The LLG acknowledges that this is not a comprehensive review.

The LLG also acknowledges that there is ongoing work in relation to the new Southern Hospital and Health Park which includes role delineation for both facilities. The result of the work will have an impact on the types and location of services in and for Franklin. The LLG will cooperate as required with this ongoing work.

Counties Manukau Health and the Franklin Locality Leadership Group recognise and respect Te Tiriti o Waitangi as the founding document of New Zealand and the obligations for partnership established by Te Tiriti.

The current population of Franklin is approximately 76,000 and is expected to grow to approximately 180,000 over the next two or three decades, spanning two local territorial authorities. Pukekohe is, and will remain, the "centre of gravity" (or least one of the significant population areas) for the current and future Franklin population. The two existing community hospitals provide a limited range of services, requiring patients to travel outside the locality for most secondary care services. No medical services are available locally after 8pm. The planned new Southern Hospital will not become operational for some years though is likely to be operational before the population reaches the projected 180,000. Meanwhile, the demand for equitable, accessible health (and wellness) services in Franklin will increase.

Franklin is distinctive because of its ethnic make-up, the age structure of its population and its rurality. Māori make up almost 20% of the Franklin population, higher than the proportion across both CMH as a whole, and the national average. A significant portion of the Franklin population are over the age of 65 years and many of these are over the age of 80 years. Distance and limited transport options are barriers to equitable healthcare, especially for those on low incomes and/or with no means of private transport. The most rural areas in Franklin experience the highest deprivation, have the highest proportion of Māori and lack all forms of public transport. These barriers are magnified when patients need access to after-hours services.

This is an opportunity to consider and implement models of care that are tailored to the needs of Franklin, perhaps challenging 'traditional' models.

Pukekohe Hospital should be expanded both in size and in the range of services provided. We envisage a community health hub where local health, wellness and social services providers can operate, sharing costs and resources where possible. Co-locating services is seen as having many advantages – not just in better utilising scarce resources but also in growing and strengthening relationships between and among those individuals and organisations working in the sector. It could be a 'one-stop shop' for health and wellness services and be a public/private/NGO/community group partnership. At least one potential partner, Franklin Hospice, is actively considering this as part of its required service expansion.

Consideration should be given to identifying actions that can be taken now and which will require minimal additional resourcing. Examples include expanding the current (and successful) out-patient clinic model, introducing new outpatient services and utilising other facilities in the locality (such as Primary Care, Huakina Trust, Franklin Hospice and other community organisations) to deliver services. The lessons learned, and improvements made, would help inform and shape the model(s) of care that could further be successfully implemented in Franklin.

Introduction

Whanaungatanga

In the ideal world, a relationship is nurtured and looked after throughout one's life time. There are always consequences when this doesn't happen. For Māori whānau, it is not limited to a family unit of immediate people. The extended whānau is as important as the immediate whānau. How an individual is treated or cared for will impact on the extended family. When Professor Sir Mason Durie presented Te Whare Tapa Whā, many adopted it but still isolated it to the area of health in which they worked. Over the years, it has appeared in many other sectors besides health. Importantly, again, people have isolated the model/framework/practice to their particular field.

Manaakitanga

The importance of the Manaakitanga for any individual and their whānau can be explained quite simply with Te Whare Tapa Whā.

If we care for people so their Hinengaro is rested, their Wairua is settled, their Tinana is strong, Whānau will have the capacity to build their knowledge, gaining the resilience to know when they need help and how they access help. *'Manaaki tangata – Manaaki whakapapa – caring for lineage past, present and future'.* The holistic view is that when you support any whānau member to become healthier, you are not only looking after that person but also their tupuna (ancestors) and their mokopuna (grandchildren).

Following discussions at the Franklin Locality Leadership Group (LLG) on the future community health needs of the Franklin Locality, the LLG determined that it had a responsibility to take an active (leadership) approach to these needs and to present its considered views and recommendations to Counties Manukau Health. This is not intended to be a comprehensive plan but rather a synopsis of the discussions and subsequent recommendations of the Franklin Locality Leadership Group.

Vision

To provide improved and equitable access to a range of integrated health and wellness services, with a holistic approach that is appropriate for current and future population needs.

Current Situation

The current population of Franklin is approximately 76,000 and is expected to grow to approximately 180,000 over the next 30 years. It has a mix of urban and rural residents and is the largest CMH locality by area. Almost 20% of the population is Māori and there is a high percentage of elderly.

For many of our residents, especially those living on a low income and/or living in rural areas, accessibility is already an issue. Those requiring treatment that is beyond the scope of primary care have no alternative but to travel (or be transported) long distances. This is very time consuming and

results in high travel (and at Middlemore, parking) costs. It is a significant barrier to accessing high quality and necessary treatment.

There are nine general practices and a range of NGOs providing services in the locality.

There are two community hospitals: Pukekohe Hospital and Franklin Memorial Hospital (Waiuku). Neither provides acute inpatient medical, surgical or A&M services. Local GPs are contracted to provide medical officer coverage, at Pukekohe Hospital during the day, and across both facilities after hours. Neither hospital allows for 24-hour, 7 day a week patient admissions, which has proven to be problematic on occasion. A CMH Health of Older People Specialist provides specialist geriatric services.

Pukekohe Hospital has seen a significant increase in staff using that facility as a base and in the number of outpatient clinics operating at the hospital. However, data from the 2017 year show that only 7% of appointments for patients who live in Franklin were provided at Pukekohe Hospital. The remaining appointments (53,587) were provided at other facilities, primarily Manukau Health Park and Middlemore Hospital. Some services, e.g. Allied Health and Respiratory Medicine are delivered from Pukekohe Hospital, yet the majority of appointments for Franklin patients are accessed from other facilities. (Appendix 1). Patient feedback suggests that patients from other southern parts of the DHB catchment, such as Drury and Papakura, may prefer to travel to clinics in Pukekohe rather than Manukau. While it will not be possible to provide all outpatient specialities from Locality Hubs, anecdotally we understand that most patients will – or will prefer – to return to the same place for ongoing treatment. Providing ongoing treatment locally, where possible, will help ensure patients feel they are being adequately cared for and will assist in removing or minimising some of the existing barriers to accessing such care.

Utilisation of existing and emerging telehealth technologies would enable services to be delivered locally in some cases and having a resource – a navigator – to provide Kaimanaaki and help guide patients through the health system would also be beneficial.

Pukekohe Hospital has two wards - a maternity ward and a Rehabilitation and Care Community ward, managed by Locality Services. The latter ward is currently capped at 20 beds. Franklin Memorial Hospital is an older brick building that does not meet current earthquake strengthening requirements. This facility currently has 16 beds in which it provides long term aged residential care as well as respite & palliative care. A range of outreach services are delivered from both the hospitals.

Both Pukekohe Hospital and Franklin Memorial Hospital have beds for palliative care patients but do not have specialist palliative care doctors or nurses on staff. The ageing population and increased awareness have seen a 50% increase in new patient referrals and a 30% increase in the number of patients being seen at any given time under the care of Franklin Hospice in the 2019/20 year. There were 234 (156 in 2018/20 and 147 in 2017/18) new patient referrals and the hospice supported 310 (240 and 200) patients and their families.

There is one private Accident & Medical (A&M) facility in Franklin operating daily from 8.00am to 8.00pm. The nearest and only public Emergency Department services are at Middlemore Hospital. To illustrate the after-hours A&M need, in the period January to July 2019, 2,056 Franklin residents presented to Middlemore ED between 8.00pm and 8.00am. This averages at 294 per month or approximately 73 per week – more than 10 per day. 633, almost one third of presentations, are subsequently admitted to hospital. As the population grows, the number requiring Emergency Department services will increase. These figures relate only to the Franklin Locality and do not take

into account presentations from other southern parts of the CMH catchment (Appendix 2). Further examination of the data by triage category will determine what percentage of these were appropriate ED presentations versus those which could have been seen in an A&M facility.

The LLG is aware that a new private surgical hospital, providing elective and other investigations and procedures, is planned in Pukekohe, with a completion date of April 2021.

The Northern Regional Alliance through its Long Term Investment Plan has indicated that a new hospital in the Southern Corridor (the Southern Hospital) is required. This Long Term Investment Plan indicates that the first phase would provide 150 beds by 2026/27, an additional 150 beds by 2031/32 and a total of 350 beds by 2036/37. The LLG is not aware of any decision having been taken as to its intended location.

The LLG acknowledges that the report from Health and Disability System Review (the Simpson Review) has been presented and some or all of its recommendations could be implemented in the years to come which may well impact on the type, shape and location of services in the area.

Issues

Key issues identified are:

a. Pukekohe is – and is likely to remain – the centre of gravity (or at least one of the major centres) for the Franklin population.
b. Most outpatient services for Franklin residents are not delivered in Franklin. Patients and whānau are required to travel long distances to access services. This is costly in both time and money.
c. Distance and cost of travel are barriers to accessing health care, especially as there are limited public transport options in the locality (outside of Pukekohe).
d. Neither Pukekohe nor Franklin Memorial Hospital allows for 7 day/24-hour patient admissions.
e. The present contract for medical officer coverage at Pukekohe Hospital is temporary.
f. The inpatient ward is under-utilised.
g. Both Pukekohe Hospital and Franklin Memorial Hospital have beds for palliative care patients but do not have specialist palliative care doctors or nurses.
h. Franklin Memorial Hospital does not meet current earthquake strengthening requirements.
i. The private A&M facility has limited hours (8am – 8pm). Outside of those hours, patients need to travel, or be transported, out of the area (usually to Botany or Middlemore Hospital).
j. The Surgical bus visits Pukekohe Hospital periodically and performs public funded operations, and some GPs with Specialist Interest (GPSI) perform excisions for patients on the public plastic surgical waiting lists funded by CMH.
k. A limited, but increasing, number of out-patient clinics are provided locally. The increase in outpatient services provided at Pukekohe Hospital is placing a strain on existing resources.
l. The importance of the role of and communication with family/whanau in the provision of total healthcare needs to be acknowledged.
m. The need to ensure ongoing provision of training in cultural sensitivity and cultural awareness.

Proposal

The Franklin Locality Leadership Group presents the following for consideration by CMH:

a. The CMH facilities in Pukekohe should be upgraded and expanded taking into account the planning of the new Southern Hospital. The hospital is already at or near capacity for staff and for the current level of outpatient clinics. Consider, where appropriate, interim solutions that could grow current capacity including the contracting of some capacity/services from local resources.
b. A health and wellness 'hub' should be developed, – a 'Wellness Centre' - for the community where other community run services could be delivered such as Allied Health Care, counselling, supported housing and social services. In short, a 'one stop shop' for residents. Such a facility would also act as a point of contact for locals to access information about services that are available locally, whether or not these are provided at Pukekohe Hospital.
c. Expanded outpatient services in Franklin will reduce the burden of travel for residents in the southern part of the DHB, and the Franklin load on Manukau Health Park, potentially freeing up capacity for patients from other localities. Following consultation with the local Franklin GP Principals & the wider Primary Health Care Team, we have compiled a list of clinics/ investigations/procedures that we feel could be provided at the Pukekohe Hospital site. Some of these could be set up in the short term (i.e. by the winter of 2021) and others could be considered medium term goals. Accessibility for patients would be greatly increased – this could lead to a much lower DNA rate and work towards achieving greater equity for our patients. The list (which is not meant to be exhaustive) is attached as Appendix 3. <u>It would be a significant move towards making our local healthcare services 'Better, Sooner and More Convenient'.</u>
d. Consider the use of current and emerging technologies such as Telehealth and virtual First Specialised Appointments (FSA's). Not just at Pukekohe Hospital but also in primary care settings.
e. Consider what changes to the current model of care could be implemented in the short term which will have little or no impact on resourcing. Examples might include clinics at other local facilities including Primary Care (consider these as 'spokes' in a 'hub and spoke' model).
f. Consider expanding the use of the Hospital in the Home (and potentially a Hospice in the Home) model of care.
g. Upskilling nursing staff and determining the most appropriate model of medical cover to increase the capacity and capability of the inpatient ward, to enable community admissions and the care of low acuity medical patients in Pukekohe.
h. Explore, with Franklin Hospice, ideas being considered by the hospice for models for the delivery of both inpatient and outpatient Palliative Care in Franklin, including co-location, with a view to strengthening the existing relationships and operating a 'shared care' model for those palliative patients requiring treatment that is best provided in the equivalent of a hospice IPU. The hospice could be separate from the hospital but attached to it to enable free and easy access for both staff and patients.
i. Diagnostic facilities in Franklin (Medical Imaging and Laboratory Diagnostics) need to be increased and made more accessible, including the use of point of care testing as well as either developing a DHB facility at an expanded Pukekohe Hospital, or by making better use of existing and future local resources by contracting with other providers, for example, to allow for after-hours diagnostics.

j. Increased minor surgery, diagnostic and other procedures could be delivered on a day stay basis. Examples include: endoscopy, cardiac investigations including echocardiography, chemotherapy, transfusions and the return of renal dialysis.
k. Consider the development of a 24-hour short stay observational facility.
l. Further work with Mental Health and Women's Health to ensure any developments include these service demands and requirements.
m. Explore the possibilities for a 'One Stop Shop' in a central location in Pukekohe to improve accessibility and reduce the barriers to healthcare for youth and young adults.
n. Realising that such development will incur significant capital and operational costs, consider a public/private/NGO/community model where costs are shared.
o. Whatever the final concept, planning for implementation is likely to reflect multiple phases but the key element is that a common vision and concept (and the subsequent plan) is agreed and committed to by all.

Collaboration

It is important that we continually discuss how our organisations work together to care for whānau in a holistic way. The most important aspect of care is ensuring the patient and their whānau are treated with dignity and respect and are able to easily access the right health & social care, at the right time to meet their needs

Feasibility

The feasibility of expanding the Pukekohe facility could/should consider:

a. The community view of Pukekohe as the centre of Franklin.
b. Expansive land on the current site.
c. Population growth.
d. Aging population.
e. Poor public transport options.
f. Lessen the demand on other CMH services at Manukau Health Park and Middlemore ED, after hours.
g. Reduce inequities in access to healthcare.
h. Opportunities for new models of care and provision of facilities (partnerships).

A Staged Approach

The LLG recognises that improvements to the delivery of health and wellness services, which are likely to incorporate changes to the current Model of Care, will take time to implement. We believe an integrated model addressing health, psycho-social, housing etc needs will best meet the requirements of our population. A staged approach could be adopted starting almost immediately.

a. **Short Term.** By the winter of 2021:
    i. Address current space constraints and increase the number of out-patient and procedural services provided from Pukekohe Hospital. Some services, for example, hospice out-patient clinics, could be implemented relatively quickly.
    ii. Upskill nursing staff and strengthen the model of medical care to expand current in-patient services at Pukekohe Hospital.
b. **Medium Term.** In 2-10 years:
    iii. Establish a community hub (and spaces) with integrated DHB and community services.
    iv. Collocate Franklin Hospice to Pukekohe Hospital Grounds.

v. Introduce minor surgery, diagnostic and other day stay treatments and procedures, at a purpose-built facility or in partnership with other providers across Primary Care and potentially private providers as they develop).
vi. Review the need for extended out of hours accident and medical services- ideally 24 hours, 7 days per week, within the broader geographical area.

c. **Long Term.**

vii. Continue to address health inequity in the locality.

Recommendation

It is recommended that this report is considered and that an action plan is developed and implemented.

Andy Baker
Chair
Franklin Locality Leadership Group

Appendices:

1. Outpatient Usage Franklin Patients, 2017 (Carl Eagleton)
2. ED Presentations After Hours (8pm – 8am)
3. Suggested List of Clinics/Investigations/Procedures

Appendix 1

Outpatient Usage Franklin Patients, 2017 (Carl Eagleton)

7% of appointments for patients who live in Franklin are currently provided at Pukekohe Hospital

Specialty	Attended	Cancelled	Did not attend	Not specified	Grand Total
Allied Health and other	494	29	122	39	684
Anaesthesia Services(s) and Pain Management	143	30	42	9	224
Cardiology	227	11	89	4	331
Diabetology		15		1	16
Geriatric A, T & R (active rehabilitation)	83	9	6	1	99
Gynaecology	64	5	19	5	93
Maternity services - mother [no community LMC]	686	33	62	50	831
Oncology	40	3	1	10	54
Respiratory Medicine	880	115	80	209	1284
Rheumatology	109	13	9	5	136
Grand Total	**2726**	**263**	**430**	**333**	**3752**

The remaining appointments are provided at other facilities e.g. MMH, MSC, others.

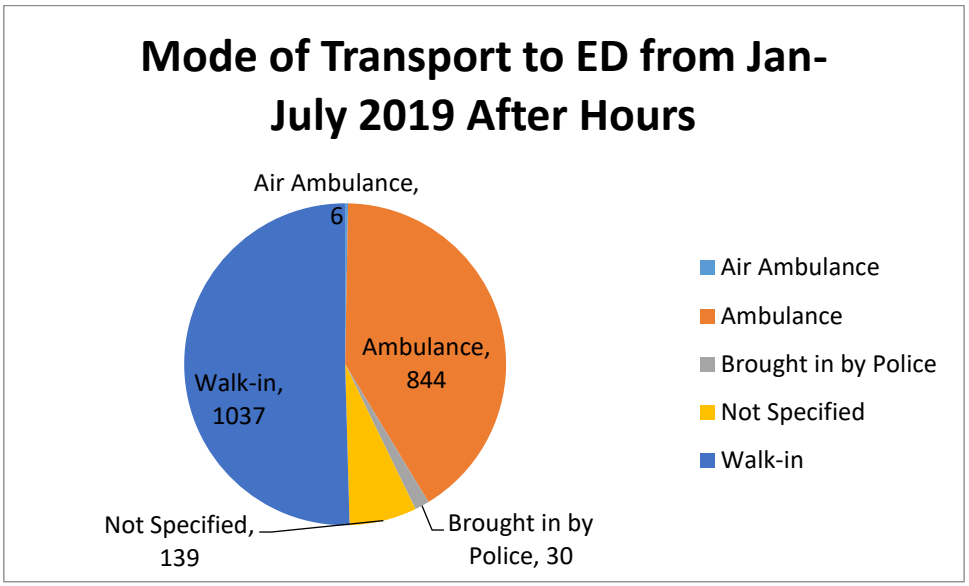
Some services e.g. Allied Health, Respiratory Medicine are delivered from Puke Hospital, yet the majority of appointments for Franklin patients are accessed from other facilities.

Specialty	Appointments (NOT AT PUKE)
Ophthalmology	6284
Orthopaedic Surgery	5964
Cardiology	5664
Plastic Surgery [excluding burns]	4791
General Surgery	3888
Allied Health and other	3705
Gastroenterology	2976
Respiratory Medicine	2853
Haematology	2522
Otorhinolaryngology (ENT)	2423
Gynaecology	1851
Paediatric Medicine	1285
Urology	1145
Renal Medicine	978
Rheumatology	958
General Medicine	897
Dermatology	866
Diabetology	852
Geriatric A, T & R (active rehabilitation)	797
Anaesthesia Services(s) and Pain Management	566
Specialist Interventionist Radiology	547
Maternity services - mother [no community LMC]	545
Oncology	358
Endocrinology	291
Not specified	173
Infectious Diseases	137
Neurology	88
Dental Surgery	57
Physical disability A,T & R sub-series	34
Specialist Paediatric Neurology	30
Maternity services - mother [with community LMC]	27
Emergency Medicine	21
Paediatric neonatal special / intensive care [Level III]	6
Burns Surgery	5
Specialist medical genetics	2
Adult mental health services	1
Grand Total	**53587**

1

Appendix 2

ED Presentations after Hours (8pm-8am)



Appendix 3

Suggested List of Clinics/Investigations/Procedures

- Cardiology- Outpatient Clinic/ Echocardiography/ 24hour BP recording/ 24hour Halter ECG recording/ Nurse-run Heart Failure Titration Clinic.
- Gastro-enterology- Outpatient Clinic/ gastroscopy/ colonoscopy.
- Plastic Surgery/ Hands – LAOP/ 'see and treat' clinic for skin cancers / skin graft reviews & wound checks. Outpatient Clinic offering Carpal Tunnel injections/ Trigger finger injections.
- Gynaecology- Outpatient Clinic/ Urodynamics & bladder studies (up to 2 year wait at moment?)/Pelvic Floor Physiotherapy/ colposcopy.
- Oral Surgery/Dental Health- assessments/ extractions.
- Memory Assessment Clinic.
- Haematology- Venesections/ Blood transfusions/ Chemotherapy (CTX) – maybe future development for Oncology CTX also.
- Dietetic Services- widening of services provided to different groups of patients.
- Renal Dialysis.
- Urology- Outpatient Clinic.
- Orthopaedics- expansion of General Outpatient Clinic/ joint injections e.g. trochanteric bursitis.

Counties Manukau District Health Board Meeting
Resolution to Exclude the Public

Resolution
That in accordance with the provisions of Schedule 3, Clause 32 and Sections 6, 7 and 9 of the NZ Public Health and Disability Act 2000:

Mr Ken Whelan, Crown Monitor, Ms Ngataki and Ms Brittany Stanley-Wishart are allowed to remain for the Public Excluded section of this meeting.

The public now be excluded from the meeting for consideration of the following items, for the reasons and grounds set out below:

General Subject of items to be considered	Reason for passing this resolution in relation to each item	Ground(s) under Clause 32 for passing this resolution
Public Excluded Minutes of 28 October 2020	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Confirmation of Minutes** As per the resolution from the public section of the minutes, as per the NZPH&D Act.
Cardiac Cath Lab & Renal Dialysis Extension Construction Budget	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]
T-DOC Single Instrument Tracking Implementation Business Case	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]
e-Ward Whiteboard Implementation Business Case	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]

Data Warehouse & Qlik	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]
2019/20 Annual Report	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Confidentiality of advice by officials** The disclosure of the information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by Ministers of the Crown and officials. [Official Information Act 1982 S9(2)(f)(iv)
Bad Debt Write Offs	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Privacy** The disclosure of information would not be in the public interest because of the need to protect the privacy of natural persons. [Official Information Act 1982 S9(2)(a)]
Insurance – National Disaster Risk Sharing Proposal	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]
FPIM Programme Service Agreement	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]

Draft DiSAC ToR	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]
Appointment of ARF Chair	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]
Spinal Rehabilitation Service Requirements	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]
Chief Executive's Report	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Public Interest** The disclosure of information is necessary to protect information that would be likely to otherwise damage the public interest. [Official Information Act 1982 S9(2)(ba)(ii)]
Changing the Age of Eligibility for Breastscreening	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]

Age Extension in the National Bowel Screening Programme	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]
Strategy & Infrastructure Report	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities and Negotiations** The disclosure of the information would not be in the public interest because of the greater need to enable the organisation to carry on, without prejudice or disadvantage, commercial activities and negotiations. [Official Information Act 1982 S9(2)(i) & (j)
Risk Management Report	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Public Interest** The disclosure of the information is necessary to protect information that would be likely to otherwise damage the public interest. [Official Information Act 1982 S9(2)(ba)]
Northern Region Service Plan 2020/21	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Confidentiality of advice by officials** The disclosure of the information would not be in the public interest because of the greater need to enable the Board to maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by Ministers of the Crown and officials. [Official Information Act 1982 S9(2)(f)(iv)
Grow Manukau Concept Design	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities** The disclosure of information would not be in the public interest because of the greater need to enable the Board to carry out, without prejudice or disadvantage, commercial activities. [Official Information Act 1982 S9(2)(i)]

Subway Lease Extension	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Commercial Activities and Negotiations** The disclosure of the information would not be in the public interest because of the greater need to enable the organisation to carry on, without prejudice or disadvantage, commercial activities and negotiations. [Official Information Act 1982 S9(2)(i)&(j)
Public Excluded Minutes of Audit Risk & Finance Committee, Hospital Advisory Committee & Community & Public Health Advisory Committees	That the public conduct of the whole or the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist, under section 6, 7 or 9 (except section 9(3)(g)(i))of the Official Information Act 1982. [NZPH&D Act 2000 Schedule 3, S32(a)]	**Confirmation of Minutes** As per the resolution from the public section of the minutes, as per the NZPH&D Act.